MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Edmund P. Kemp

Director, Program Policy Division
Bureau of Policy and Federal Affairs
Policy and Legal Affairs Administration

Project Number:	0216-CMHSP	**Comments Due:**	1/13/03	**Proposed Effective Date:**	XX/XX/XX

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Policy Subject: Revised Chapter III for Prepaid Health Plans, Mental Health and Substance Abuse

Affected Programs: Medicaid

Distribution: Community Mental Health Services Programs

Policy Summary:

Changes have been made in the current policy to reflect the following:

- Prepaid health plans will become the responsible managing entities for Medicaid services on 10/1/02
- Alternatives and allowable services have been removed because of the potential for interpreting them as entitlements
- Extraneous contractual and instructional material has been removed
- Update and clean-up of inconsistencies and redundancies

Proposed Policy Draft

Michigan Department of Community Health
Medical Services Administration

Distribution: Community Mental Health Services Programs

Issued: XX/XX/XX

Subject: Revised Chapter III for Prepaid Health Plans, Mental Health and Substance Abuse

Effective: XX/XX/XX

Programs Affected: Medicaid

The attached revised Chapter III for Prepaid Health Plans, Mental Health and Substance Abuse manual contains comprehensive revisions that reflect changes in the management of mental health and substance abuse services effective January 1, 2003. This revision also removes alternative and allowable services from the policy per order of the Policy Hearing Authority Decision of May 31, 2002. Finally, the revision eliminates redundancies and updates language.

CHAPTER III - COVERAGES AND LIMITATIONS

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DCH APPROVAL

Pursuant to Michigan's federally-approved 1915(b) and (c) waivers, community-based mental health, substance abuse and developmental disability specialty services are covered through the Medicaid Program when delivered under the auspices of an approved prepaid health plan (PHP). In order to provide services through the Medicaid Program, PHPs must be certified as CMHSPs by the Michigan Department of Community Health (DCH) in accordance with Section 232a of the Mental Health Code. PHPs must be enrolled with DCH as Medicaid providers. PHPs that were previously enrolled as CMHSP Medicaid providers do not need to re-enroll. The PHP must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, being Public Act 258 of 1974, as amended, and those specialty services/supports included as covered services in this manual. The 1915(b) and (c) waivers permit Michigan to offer covered Medicaid services and home and community-based services. Section A.1.a. of the Social Security Act permits alternative services to be provided at the discretion of the PHP out of its capitation payment. The alternative services are described in the DCH/PHP contract. Individuals may select, during person-centered planning, a mix of covered and alternative services, or covered or alternative services only, depending on what services best meet their needs and will assist them in achieving their goals.

STANDARDS

The PHP shall comply with the standards for organizational structure, fiscal management, administrative recordkeeping, and clinical recordkeeping specified in this section. In order for a service to be claimed as a Medicaid cost, it must meet the criteria in this chapter.

ADMINISTRATIVE ORGANIZATION

The administrative organization shall assure effective operation of the various programs and agencies in a manner consistent with all applicable federal and state laws, regulations, and policies. There shall be clear policy guidelines for decision-making and program operations and provision for monitoring same.

PRUDENT PURCHASE

The PHP shall employ a prudent purchase principle when considering the purchase or direct provision of services and supports. Prudent purchase is a combination of quality and cost, where quality is measured by the ability to meet the beneficiary's need, reflected in the individual plan of service, and cost is measured by being the most reasonable and economical approach necessary to meet that need. The PHP shall assist the beneficiary to explore all their first- and third-party resources, to pursue all reimbursements to which they may be entitled, and assist the beneficiary to make use of other community resources for non-covered services.

PROVIDER REGISTRY

The PHPs must register with DCH any Medicaid service they provide directly or through one of their contracted providers as specified in the DCH/PHP contract. The PHPs should refer to the provider registry and DCH approval of special programs.

PROGRAMS REQUIRING SPECIAL APPROVAL

Certain programs and services require the PHP to request specific approval of the DCH prior to service delivery. Programs must be registered and approved by DCH prior to service provision in order to be claimed as a Medicaid cost. Programs/services requiring specific approval are:

- Home-Based services
- Assertive Community Treatment programs
- Clubhouse psychosocial rehabilitation programs
- Crisis Residential programs
- Day programs
- Intensive Crisis Stabilization
- Children's Waiver

The PHP must notify DCH of changes in providers of these services, changes that substantially impact/alter the basis upon which approval was given; and change of address or discontinuation of these programs and services.

BENEFICIARY ELIGIBILITY

Eligibility for specialty services and supports requires that the Medicaid beneficiary needs access to a continuum of mental health care. Such need must be documented in the individual's clinical record.

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others and identified in the plan of service must be medically necessary, appropriate to the individual's needs, and meet the standards herein. A person-centered planning process must be used in selecting services and supports with mental health program beneficiaries.

MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES

Mental health and developmental disabilities services must be:

- Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services.
- Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.
- Coordinated with other community agencies (including, but not limited to, comprehensive health care plans, family courts, local health departments, MIChoice waiver providers, school-based services providers, and the county Family Independence Agency offices).
- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan shall be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which he/she is entitled. Therefore, each plan of service must contain the date any authorized service is to commence, and the specified scope, duration and intensity of each authorized service.

SUBSTANCE ABUSE SERVICES

Substance abuse services must be furnished by service providers licensed by the Michigan Department of Consumer and Industry Services to provide each type of substance abuse services for which they contract. Substance abuse service providers also must be accredited as an alcohol and/or drug abuse program by one of the following national accreditation bodies:

- Joint Commission on Accreditation of Health Care Organizations
- Commission of Accreditation of Rehabilitation Facilities
- American Osteopathic Association
- Council on Accreditation of Services for Families and Children
- National Committee on Quality Assurance

Substance abuse services must be coordinated with other community services as appropriate to an individual's needs and circumstances. Services must also be provided according to an individualized written plan of service. All standard requirements of the Public Health Code apply.

LOCATION OF SERVICE

Covered services may be provided at or through PHP service sites or contractual provider locations. Unless otherwise noted in this manual, mental health and developmental disabilities services may also be provided in other locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness.

Substance abuse covered services must generally be provided at MDCIS-licensed sites. Some activities, including outreach, may be provided in community (off-site) settings by licensed providers. Case management may be provided off-site to a limited extent, as necessary, to meet the individual needs when case management is purchased as a component of a licensed service.

For beneficiaries residing in *nursing facilities*, only the following clinic services may be provided:

- Nursing facility mental health monitoring
- Psychiatric evaluation
- Psychological testing, and other assessments
- Treatment planning
- Individual therapy, including behavioral services
- Crisis intervention
- Services provided at enrolled day program sites

Medicaid does not cover services provided to beneficiaries involuntarily residing in non-medical public facilities (such as jails or prisons). Medically necessary specialty services may be provided in situations when a child is temporarily placed in a non-medical public facility because placement in another facility (e.g., foster care) is not immediately available.

DAY PROGRAM SITES

The PHP may organize a set of covered services at a day program site, but the site must be certified by DCH. For the purposes of this manual, mental health and developmental disabilities day program sites are defined as settings other than the beneficiary's/family's home, nursing facility, or a specialized residential program:

- Where an array of mental health or developmental disability services and supports is provided.
- Through a predetermined schedule, typically in group modalities.
- By staff under the supervision of professional staff who are licensed, certified, or registered to provide health-related services.

Medicaid providers wishing to provide mental health and/or developmental disability services and supports at a day program site must obtain approval of the day program by the DCH. Departmental approval will be based upon adherence to the following requirements:

- Existence of a program schedule of services and supports.
- Existence of an individual beneficiary schedule of covered services and supports with amount, duration and scope identified.
- The beneficiary's services and supports must be based upon the desired outcomes and/or goals of the individual defined through a person-centered planning process.
- Services and supports must be delivered by, or under the supervision of, professional staff who are licensed, certified, or registered to provide health-related services within the scope of practice for the discipline.
- If services are delivered under professional supervision, that supervision must be documented in the individual's clinical record.

Approval of new programs will be contingent upon submission of acceptable information to the DCH by the PHP, and upon a site visit by DCH.

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GENERAL INFORMATION

This program is limited to the covered services listed below. The PHP is not responsible for providing covered services that DCH, as the single state agency, has designated another agency to provide.

APPLIED BEHAVIORAL SERVICES (PREVIOUSLY KNOWN AS BEHAVORIAL MANAGEMENT REVIEW)

Behavioral services are actively designed to reduce maladaptive behaviors, to maximize behavioral self-control, or to restore normalized psychological functioning, reality orientation, and emotional adjustment, thus enabling the beneficiary to function more appropriately in interpersonal and social relationships. These may be provided on an individual or group basis.

Development, review, and approval of a behavioral treatment plan must be completed according to the requirements of the DCH. All PHPs shall have a specially constituted body comprised of at least three individuals, one of which possesses both formal training and at least one year of experience in applied behavior analysis. At least one of the aforementioned individuals shall be a fully- or limited-licensed psychologist with the training or experience in applied behavior analysis; and at least one member shall be a licensed physician/psychiatrist who is not specifically required to have a background in applied behavior analysis. Behavioral services are delivered according to a behavioral plan that is based on a comprehensive assessment of the behavioral needs of the beneficiary.

Plans of treatment that incorporate aversive, restrictive, intrusive techniques or psycho-active medications that are utilized for behavior control purposes and where the target behavior is not due to an active substantiated psychotic process must be reviewed and approved (or disapproved) by the body described above. Review and approval (or disapproval) of such treatment plans shall be done in light of current research and prevailing standards of practice as found in current refereed psychological/psychiatric literature. Such reviews shall be completed as expeditiously as possible.

ASSERTIVE COMMUNITY TREATMENT

See Section 5 for specific program requirements.

ASSESSMENTS

HEALTH ASSESSMENT

Health assessment includes activities provided by a physician, registered nurse, physician assistant, nurse practitioner, or dietitian to determine the beneficiary's need for services and to recommend a course of treatment.

PSYCHIATRIC EVALUATION

A comprehensive evaluation, performed face-to-face by a psychiatrist, that investigates a beneficiary's clinical status including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination.

This examination concludes with a written summary of positive findings, a biopsychosocial formulation and diagnostic statement, an estimate of risk factors, initial treatment recommendations, estimate of length of stay when indicated, and criteria for discharge.

PSYCHOLOGICAL TESTING

Standardized projective tests and IQ tests rendered by full, limited-licensed, or temporary-limited-licensed psychologists. The beneficiary's clinical record must indicate the name of the person who administered the tests and the actual tests administered. The protocols for testing must be available for review.

ALL OTHER ASSESSMENTS AND TESTING

Generally accepted professional assessments or tests, other than psychological tests, that are conducted for the purposes of determining level of functioning and treatment needs of the beneficiary are covered. This includes the administration of screening tools for the presence of extrapyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.

CASE MANAGEMENT

See Section 8 for specific program requirements.

CHILD THERAPY

Treatment activity designed to reduce maladaptive behaviors, to maximize skills in behavioral self-control, or restore normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships. Child therapy may be on an individual or group basis.

CLUBHOUSE PSYCHOSOCIAL REHABILITATION PROGRAMS

See Section 6 for specific program requirements.

CRISIS INTERVENTIONS

Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy.

The standard for whether or not a crisis exists is a “prudent layperson” standard. That means that a prudent layperson must be able to determine from the beneficiary’s symptoms that crisis services are necessary.

CRISIS RESIDENTIAL SERVICES

See Section 7 for specific program requirements.

FAMILY THERAPY

Therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling.

HEALTH SERVICES

Health services are provided for purposes of improving the beneficiary's overall health and ability to care for health-related needs. This includes nursing services (on a per-visit basis, not on-going hourly care), dietary/nutritional services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, and teaching the beneficiary to seek assistance in case of emergencies. Services must be provided by a physician, registered nurse, physician's assistant, nurse practitioner, or dietician, according to the scope of practice. Health services must be carefully coordinated with the beneficiary's health care plan so that health plan services are not supplanted.

HOME-BASED SERVICES

See Section 4 for specific program requirements.

INDIVIDUAL/GROUP THERAPY

Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships.

INTENSIVE CRISIS STABILIZATION SERVICES

See Section 12 for specific program requirements.

MEDICATION ADMINISTRATION

The process of giving a physician-prescribed oral medication, injection, or topical medication treatment to a beneficiary.

MEDICATION REVIEW

Evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen.

NURSING FACILITY MENTAL HEALTH MONITORING

Review of the beneficiary's response to mental health treatment, including direct beneficiary contact and, as appropriate, consultation with nursing facility staff to determine whether recommendations from mental health assessments are carried out by the nursing facility. Nursing facility mental health monitoring is intended to allow follow-up for treatment furnished in response to emerging problems or

needs of a nursing facility resident. It is **not** intended to provide ongoing case management, nor is it for monitoring of services unrelated to the mental health needs of the beneficiary.

OCCUPATIONAL THERAPY

EVALUATION

Activities provided by an occupational therapist currently registered by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment.

THERAPY

Application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health. The term “occupation,” as used in occupational therapy, refers to any activity engaged in for evaluating and treating problems interfering with functional performance.

Therapy must be skilled (requiring the skills, knowledge, and education of a registered occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.

Services must be prescribed by a physician and may be provided on an individual basis or on a group basis by an occupational therapist currently registered by the State of Michigan, or an assistant (the occupational therapist must supervise and monitor the assistant’s performance with ongoing assessment of the beneficiary’s progress). The occupational therapist need not provide on-site supervision at all times, but must be available by telephone at all times, and hold regularly scheduled supervisory meetings. An aide performing a service must be supervised on-site by a qualified occupational therapist.

PERSONAL CARE IN SPECIALIZED SETTINGS

See Section 9 for specific program requirements.

PHYSICAL THERAPY

EVALUATION

Activities provided by a physical therapist currently licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment.

THERAPY

Physician-prescribed treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability.

Physical therapy must be skilled (it requires the skills, knowledge, and education of a licensed physical therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, registered occupational therapist, family member or caregiver) would not be considered as a Medicaid cost under this coverage.

Services may be provided by a physical therapist currently licensed by the State of Michigan, or an assistant (the physical therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress), or an aide who is under the supervision of a physical therapist currently licensed by the State of Michigan.

SPEECH, HEARING, AND LANGUAGE

EVALUATION

Activities provided by a speech pathologist or audiologist to determine the beneficiary's need for services and to recommend a course of treatment.

THERAPY

Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (M.D., D.O.).

Speech therapy must be skilled (i.e., requires the skills, knowledge, and education of a certified speech/language pathologist) to assess the beneficiary's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, registered occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.

SUBSTANCE ABUSE

See Section 15 for specific program requirements relating to substance abuse services.

TREATMENT PLANNING

Activities associated with the development and periodic review of the plan of service, including all aspects of person-centered planning and pre-meeting activities. This includes writing goals, objectives, and treatment plans; designing treatment strategies (identifying sufficiency, scope, intensity, and duration) and data collection methodologies; attending team meetings, if applicable; and related documentation.

TRANSPORTATION

Transportation to and from the beneficiary's place of residence when provided so a beneficiary may participate in a covered mental health clinic or rehabilitation service at an approved day program site or psychosocial rehabilitation program. The Family Independence Agency rules should be followed for medical transportation services.

GENERAL INFORMATION

Mental health home-based service programs are designed to provide intensive services to children and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to promote normal development, promote healthy family functioning, support and preserve families, reunite families who have been separated, and reduce the usage of, or shorten the length of stay in, psychiatric hospitals and other substitute care settings. Treatment is based on the child's need with the focus on the family unit. The service style must support a strength-based approach, emphasizing assertive intervention, parent and professional teamwork, and community involvement with other service providers.

Services may be provided by one staff, or a team of staff. Home-based services programs are designed to provide intensive services to children and families in their home and community. The degree of intensity will vary to meet the needs of families. The home-based services worker-to-family ratio should be established to accommodate the levels of intensity that may vary from two to twenty hours per week based on individual family needs. The worker-to-family ratio should not exceed 1:15 for a full-time equivalent position.

Medicaid providers seeking to become providers of home-based services must request approval from the DCH. Departmental approval will be based on adherence to the requirements outlined below.

PROGRAM APPROVAL

Applications for approval should identify the target population to be served by the program. Providers must assure that staff providing services in this program meet the required qualifications.

Information submitted to DCH must include the basic program information submitted in a format prescribed by DCH. For approved providers, DCH is available to assist the PHP in securing any necessary training and technical assistance. If necessary during an initial period, the providers may receive provisional approval that will allow them to provide services. However, any necessary additional actions must be completed within the timeframe specified by the DCH or provisional approval will be withdrawn.

ORGANIZATIONAL STRUCTURE

The PHP shall specify the organizational structure through which the mental health home-based service program shall be delivered. The structure shall meet the following requirements:

- The structure must be centralized (i.e., the staff must be assigned to an identifiable service unit of an organization with responsibility for operating the home-based services program).
- Responsibility for directing, coordinating, and supervising the program shall be assigned to a specific staff position. The supervisor of the program shall meet the qualifications of a child mental health professional with three years of clinical experience as defined in Rule 330.2125(4) of the Administrative Rules for Children's Diagnostic and Treatment Service.
- There shall be an internal mechanism for coordinating and integrating the home-based services with other mental health services, as well as general community services relevant to the child's and family's needs.

QUALIFIED STAFF

Home-based services must be delivered by appropriately qualified staff. Home-based professional staff shall meet the qualifications of a child mental health professional as defined in Rule 330.2105(b) of the Administrative Rules for Children's Diagnostic and Treatment Service. For home-based programs serving infants/toddlers and their families, staff must be trained in infant mental health interventions.

For home-based programs serving children with developmental disabilities, the child mental health professional must meet the qualifications, as defined above, and also be a Qualified Mental Retardation Professional (QMRP), as defined in 42 CFR 483.430.

Home-based services professional staff may be assisted by trained paraprofessional assistants. Home-based services assistants will assist with implementation of treatment plan behavioral goals related to positive skill development and development of age-appropriate social behaviors. Services to be provided by the home-based services assistant must be identified in the family plan of service, must relate to identified treatment goals, and must be under supervision of relevant professionals.

Home-based services assistants must be trained regarding the beneficiary's treatment plan and goals, including appropriate intervention and implementation strategies, prior to beginning work with the beneficiary and family.

FAMILY-FOCUSED PLAN OF SERVICE

Mental health home-based services shall be provided in accordance with a family-focused plan of service. The family plan of service is a comprehensive plan that identifies child and family strengths and needs, determines appropriate interventions, and identifies supports and resources. It is developed in partnership with family members and other agencies, through a person-centered planning process using a family-centered approach.

SCOPE OF SERVICE

Mental health home-based services programs combine individual therapy, family therapy, group therapy, crisis intervention, case management, and family collateral contacts. The family is defined as immediate or extended family or an individual acting in the role of family.

Services provided in a home-based services program range from assisting beneficiaries to link to other resources that might provide food, housing, and medical care, as well as providing more therapeutic interventions such as family therapy or individual therapy.

LOCATION OF SERVICE

Services are provided in the family home or community settings which all citizens use.

LEVEL OF CARE AND UTILIZATION MANAGEMENT CRITERIA

GENERAL INFORMATION

The criteria for home-based services are described below for children ages seven to seventeen years, children birth through age three years, and children age four through age six. This criteria does not preclude the provision of home-based services to an adult beneficiary who is a parent for whom it is determined home-based services would be the treatment modality that would best meet the adult beneficiary's and child's needs.

AGE SEVEN THROUGH SEVENTEEN

Operational Definition

Decisions regarding whether a child or adolescent has a serious emotional disturbance and is in need of home-based services is determined by using the following dimensions: the child has a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of the condition. For children age seven to seventeen, the Child and Adolescent Functional Assessment Scale (CAFAS) is used to make discriminations within the functional impairment dimension. All of the dimensions must be considered when determining if a child is eligible for home-based services.

Diagnosis

The child/adolescent currently has, or had any time in the past, a diagnosable behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV or ICD-9, excluding those with a diagnosis other than, or in addition to,: (I) alcohol or drug disorders, (2) a developmental disorder, or (3) social conditions (V Codes).

Functional Impairment

For purposes of qualification for home-based services, children and adolescents with two or more elevated (rated at 20 or 30) subscale scores on the Child/Adolescent section of the CAFAS and a total impairment score (8 scale sum)> 80 may be considered markedly or severely functionally impaired.

Duration/History

The following specify the length of time the youth's functional disability has interfered with his/her daily living and led to his/her referral for home-based services:

a. evidence of six continuous months of illness, symptomatology, or dysfunction; or

b. six cumulative months of symptomatology/dysfunction in a twelve-month period; or

c. on the basis of a specific diagnosis (e.g., schizophrenia), disability is likely to continue for more than one year.

BIRTH THROUGH AGE THREE

Operational Definition

Given 1) the magnitude and speed of developmental changes through pregnancy and infancy, 2) the limited capacity of the very young to symptomatically present underlying disturbances, 3) the extreme dependence of infants and toddlers upon caregivers for their survival and well-being, and 4) the exceptional vulnerability of the very young to other relationship and environmental factors, unique criteria must be applied to define serious emotional disturbance for the birth to age three population.

Operationally, the above parameters dictate that the mental health professional must be cognizant of the primary indicators of emotional disorder in very young children, and of the importance of assessing the constitutional/physiological and/or caregiving/environmental factors which reinforce the severity and intractability of the child's disorder. Furthermore, the rapid development of very young children results in transitory disorders and/or symptoms, requiring the professional to regularly re-assess children in the appropriate developmental context.

The following is a suggested procedure for determining when a beneficiary is considered seriously emotionally disturbed or at high risk for serious emotional disturbance, qualifying for Mental Health Home-Based Services.

Diagnosis

A child has a mental, behavioral, or emotional disorder sufficient to meet diagnostic criteria specified within the DSM-IV or ICD-9 not solely the result of mental retardation or other developmental disability, substance use disorder or those with a V-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.

Functional Impairment

Substantial interference with, or limitation of, the child's proficiency in performing age-appropriate skills as demonstrated by at least one indicator drawn from two of the following areas:

- General and/or specific patterns of reoccurring behaviors or expressiveness indicating affect/modulation problems, e.g., uncontrollable crying or screaming, sleeping and eating disturbances and recklessness; the absence of developmentally expectable affect, such as pleasure, displeasure, joy, anger, fear, curiosity; apathy toward environment and caregiver.
- Distinct behavioral patterns coupled with sensory, sensory motor, or organizational processing difficulty (homeostasis concerns) that inhibits the child's daily adaptation and interaction/relationships. For example, a restricted range of exploration and assertiveness, dislike for changes in routine, and/or a tendency to be frightened and clinging in new situations, coupled with over-reactivity to loud noises or bright lights, inadequate visual-spatial processing ability, etc.
- Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as determined through the assessment of child, caregiver and environmental characteristics. For example, the infant shows a lack of motor skills and/or language expressiveness, appears diffuse, unfocused and undifferentiated, expresses anger/obstinacy and whines, in the presence of a caregiver who often interferes with the infant's goals and desires, dominates the infant

through over-control, does not reciprocate to the child's gestures, and/or whose anger, depression or anxiety results in inconsistent parenting.

Assessment tools specifically targeting socio-emotional functioning of assistance in determining functional impairment include:

- Infant-Toddler Mental Health Status Exam
- Attachment-Interaction-Mastery-Support (AIMS)
- Temperament and Atypical Behavior Score (TABS)
- DC: 0-3 Classification System

Assessment instruments specifically targeting child development include:

- Bayley Scales of Infant Care and Development

Tools assessing child development in social context include:

- Infant-Toddler Family Instrument (ITFI)
- Infant-Toddler Developmental Assessment (IDA)
- Objectives/Problems Checklist
- Hawaii Early Learning Profile (HELP)

Appropriate Screening Instruments for initial triaging include:

- Ages and Stages Questionnaire (ASQ)
- Parent's Evaluation of Developmental Status (PEDS)
- Denver Developmental Screening Test II

Duration/History

The very young age and rapid transition of infants and toddlers through developmental stages makes consistent symptomatology over time unlikely. However, indicators that a disorder is not transitory and will endure without intervention include:

- The infant/toddler disorder(s) is accompanied by persistent symptoms indicating multiple barriers to normal development (regulatory disorders, inconsistent parenting, chaotic environment, etc); or
- Infant/toddler did not respond to less intensive, less restrictive intervention.

AGE FOUR THROUGH SIX

Operational Definition

Decisions regarding whether a child age four through six is seriously emotionally disturbed and in need of home-based services and supports utilize similar dimensions to older children. The dimensions include a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities and duration of condition. However, as with younger

children birth through age three, assessment must be sensitive to the critical indicators of development and functional impairment for the age group. Significant impairments in functioning are revealed across life domains in the child's expression of affect/self-regulation, social development (generalization of attachment beyond parents, capacity for peer relationships and play, etc.), physical and cognitive development, and the emergence of a sense of self.

Diagnosis

A child has a mental, behavioral or emotional disorder sufficient to meet diagnostic criteria specified within the DSM-IV or ICD-9 not solely the result of mental retardation or other developmental disability, substance use disorder or those with a V-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.

Functional Impairment

Substantial interference with, or limitation of, the child's proficiency in performing age-appropriate skills across domains and/or consistently within specific domains as demonstrated by at least one indicator drawn from at least three of the following areas:

- Impaired **physical development**, sensory, sensory motor or organizational processing difficulty, failure to control bodily functions (e.g., bed wetting).
- Limited **cognitive development**, as indicated by restricted vocabulary, memory, cause and effect thinking, ability to distinguish between real and pretend, transitioning from self-centered to more reality-based thinking, etc.
- Limited capacity for **self-regulation**, inability to control impulses and modulate anxieties as indicated by frequent tantrums or aggressiveness toward others, prolonged listlessness or depression, inability to cope with separation from primary caregiver, inflexibility and low frustration tolerance, etc.
- Impaired or **delayed social development**, as indicated by an inability to engage in interactive play with peers, inability to maintain placements in day care or other organized groups, failure to display social values or empathy toward others, absence of imaginative play or verbalizations commonly used by preschoolers to reduce anxiety or assert order/control on their environment, etc.
- **Caregiving factors** which reinforce the severity or intractability of the childhood disorder and the need for multifaceted intervention strategies (e.g., home-based services) such as a chaotic household/constantly changing caregiving environments, inappropriate parental expectations, abusive/neglectful or inconsistent parenting, occurrence of traumatic events, subjection to others' violent or otherwise harmful behavior.

Assessment tools of assistance in determining functional impairment include, but are not limited to,:

- Preschool and Early Childhood Functional Assessment Scale (PECFAS)
- Child and Adolescent Level of Care Utilization System (CALOCUS)

Duration/History

The following specify length of time criteria for determining when the youth's functional disabilities justify his/her referral for enhanced support services:

- Evidence of three continuous months of illness, or
- Three cumulative months of symptomatology/dysfunction in a six-month period, or
- Conditions that are persistent in their expression and are not likely to change without intervention.

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GENERAL INFORMATION

Assertive Community Treatment (ACT) is a set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team. The team also provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources, such as food, housing, and medical care and supports to allow beneficiaries to function in social, educational, and vocational settings. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the beneficiary. Services are provided by all members of the ACT team in the beneficiary's residence or other community locations.

ENROLLMENT

Medicaid providers wishing to become providers of ACT services must obtain approval from DCH and meet the program components outlined below.

TARGET POPULATION

ACT services are targeted to beneficiaries with serious mental illness who require more intensive and/or restrictive services or settings. Those individuals who may benefit from ACT services may also be:

- Beneficiaries with serious mental illness with difficulty managing medications without ongoing support, or with psychotic/affective symptoms despite medication compliance.
- Beneficiaries with serious mental illness with a co-occurring substance disorder.
- Beneficiaries with serious mental illness who exhibit socially disruptive behavior presenting high risk for arrest and inappropriate incarceration.
- Beneficiaries with serious mental illness who are frequent users of inpatient psychiatric hospital services, crisis services, crisis residential, or homeless shelters.
- Older beneficiaries with serious mental illness with complex medical/medication conditions.

ESSENTIAL ELEMENTS

TEAM-BASED SERVICE DELIVERY

ACT is a team-based service that includes shared service delivery responsibility. Case management services are interwoven with treatment and rehabilitative services, and are provided by all members of the team. During daily team meetings, plans for deploying the activities of the team are carried out and include discussion of urgent or emergent situations, updates on progress and any needed clinical, medical, psychosocial interventions or supports.

TEAM COMPOSITION

The ACT team requires a sufficient number of qualified staff to assure the provision of an intensive array of services on a 24-hour basis. The minimum essential ACT staffing requirements are:

- A physician who provides psychiatric coverage for all beneficiaries served by the team. The physician is considered part of the team and meets with the team on a frequent basis. The physician (M.D. or D.O.) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a Drug Enforcement Agency registration.
- A registered nurse is required.
- A team coordinator with extensive clinical experience with the target population who coordinates the team, provides direct service to beneficiaries in the community, and is licensed or certified to provide clinical supervision. The coordinator must be a Certified Social Worker (CSW), Limited Licensed Psychologist (LLP), or Licensed Professional Counselor (LPC).

Additional positions should reflect the special conditions, services or supports required by the population or special populations to be served.

- Other professional staff licensed, certified, or registered by the State of Michigan or national organizations to provide health care services.
- Other staff not licensed, certified, or registered, i.e., peer support advocates, may be part of the team under the supervision of a qualified professional. This supervision must be documented in the medical record.

STAFF-TO-BENEFICIARY RATIO

While the size of the team may vary based on the size of the caseload, a staff-to-beneficiary ratio shall be no more than 1:10, i.e., a maximum of ten beneficiaries to each member of the team. This ratio is based on the team coordinator and other team members who provide direct services, and excludes the physician and clerical/support staff.

FIXED POINT OF RESPONSIBILITY

The ACT team is the fixed point of responsibility for the psychiatric treatment of beneficiaries served by the team and for supporting beneficiaries in all aspects of community living. This includes case management and treatment planning using a person-centered process that must address all of the services and supports to be provided or obtained by the team, including any consultation with other professional disciplines and/or referrals to other supportive services as appropriate.

AVAILABILITY OF SERVICES

Availability of services must include:

- Twenty-four-hour/seven-day crisis response coverage (including psychiatric availability) that is handled directly by members of the team. If an on-call system is used, ACT cases must be transferred to the team by pager.
- The capacity to provide a rapid response to early signs of relapse, including the capability to provide multiple contacts daily with beneficiaries with emergent conditions.

INDIVIDUAL PLAN OF SERVICES

ACT services and interventions must be consistent with the medical necessity of the individual beneficiary with the goal of maximizing independence.

ELEMENTS OF ACT

"IN VIVO" SETTINGS

According to the beneficiary's preference and clinical appropriateness, the majority of services are provided in the beneficiary's home or other community locations rather than the team office.

SERVICES

ACT teams provide a wide array of clinical, medical, or rehabilitative services during face-to-face interactions that are designed primarily to help beneficiaries to live independently or facilitate the movement of beneficiaries from dependent settings to independent living. These services and supports are focused on maximizing independence and the beneficiary's quality of life, such as maintaining employment, social relationships and community inclusion. For beneficiaries with co-occurring substance use disorders, treatment that addresses the substance use disorders must be included in the individual plan of services. Integrated treatment, in which both the mental health and substance use disorders are addressed in the same program, is preferred. Providers of substance abuse treatment must meet criteria in Section 15.

ACT services may be used as an alternative to hospitalization. The following criteria shall be used to determine the appropriateness of these services as an alternative to hospitalization.

LEVEL OF CARE AND UTILIZATION MANAGEMENT CRITERIA ASSERTIVE COMMUNITY TREATMENT

GENERAL INFORMATION

Utilization of ACT services in high acuity conditions/situations allows beneficiaries to remain in their community residence and may prevent the use of more restrictive alternatives which may be detrimental to a beneficiary's existing natural supports and occupational roles. This level of care is appropriate for beneficiaries with a history of persistent mental illness who may be at risk for inpatient hospitalization, intensive crisis residential or partial hospitalization services, but can remain safely in their communities with the considerable support and intensive interventions of ACT. In addition to meeting the following criteria, these beneficiaries may also be likely to require or benefit from continuing psychiatric rehabilitation.

The ACT program is an individually-tailored combination of services and supports that may vary in intensity over time based on the beneficiary's needs and condition. Services include multiple daily contacts and 24-hour, seven-days-per-week crisis availability provided by a multi-disciplinary team which includes psychiatric and skilled medical staff.

The ACT acute service selection guideline covers criteria in the following domain areas:

A. DIAGNOSIS

The beneficiary must have a mental illness, reflected in a primary, validated, DSM-IV or ICD-9 Diagnosis (not including V Codes) including personality disorders.

B. CONDITION (FOR DETAIL, SEE SEVERITY OF ILLNESS SECTION)

Chronic and persistent mental illness exacerbated by severe symptoms; prevention of inpatient usage or other more restrictive settings, i.e., crisis residential, intensive crisis stabilization.

Other: Voluntary/Alternative Sentencing

C. UTILIZATION REVIEW

Every three to six months.

D. CO-OCCURRING SUBSTANCE USE DISORDER

Co-occurring substance use disorder with an underlying or existing psychiatric diagnosis being the primary cause of the beneficiary's current symptoms.

E. POTENTIAL CORRECTIONS INVOLVEMENT

High Risk Factors

Youthful offenders
Males
History of poor family relationships
Unstable housing/Homelessness
Criminal justice involvement
Suicide attempts
Emergency Room and other acute care visits

Secondary Risk Factors

Peer or family substance abuse
Criminal recidivism
Family history of mental health disorders
Aggressive and violent behavior
Poor treatment outcomes
Other undesirable behavior

F. SEVERITY OF ILLNESS

At least one of the following manifestations is present:

Psychiatric Signs and Symptoms

Severe psychiatric signs and symptoms, with indications (past history, rapid fluctuations in symptom severity related to marked stressors, uncertain etiology of immediate condition, etc.) that these signs and symptoms may not persist in intensity or duration.

Self-Care/Independent Functioning

Disruptions of self-care, limited ability to attend to basic physical needs (nutrition, shelter, etc.), seriously impaired interpersonal functioning, and/or significantly diminished capacity to meet educational/occupational role performance expectations.

Drug/Medication Conditions

Drug/medication compliance and/or coexisting general medical condition which needs to be simultaneously addressed along with the psychiatric illness and which cannot be carried out at a less intensive level of care.

Risk to Self or Others

Potential danger to self; potential danger to others.

G. SEVERE PSYCHIATRIC SIGNS AND SYMPTOMS

Prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) which may manifest as intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc., and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance.

Risk

Symptom acuity does not pose an immediate risk of substantial harm to the person or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged.

H. DISRUPTIONS OF SELF-CARE AND INDEPENDENT FUNCTIONING

Able to maintain adequate nutrition, housing or other essentials of daily living only with monitoring and assistance by the ACT team.

Deterioration and incapacity in meeting major life role responsibilities and expectations, i.e., family, educational and occupational roles.

Due to a mental disorder, serious neglect of self-care tasks and/or does not sufficiently attend to essential aspects of daily living: adequate nutrition, shopping, meal preparation, housekeeping chores, paying bills, etc.

Interpersonal relationships and functioning are significantly impaired: seriously dysfunctional communication, extreme social withdrawal, etc.

Harm to self, danger to self, as indicated by statements of the beneficiary, recent actions or gestures, or reckless activities related to confusion, poor judgment or impulsivity.

Self-Mutilation and/or Reckless Endangerment

Evidence of current behavior, or recent history.

Verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors. An assessment of judgment would suggest an ability to maintain control over this ideation.

Other Self-Injurious Activity

Some danger to self, as indicated by statements of the beneficiary, recent actions or gestures, or reckless activities related to confusion, poor judgment or impulsivity.

I. HARM/DANGER TO OTHERS

The person may have a history of assaultive behavior or has threatened others verbally, but there have been no assaultive actions, no preparation for such actions, and there is nothing in the person's recent behavior to suggest these threats will be carried out.

Person verbalizes minor threats or expresses nonspecific hostility toward others, but appears to have sufficient judgment and impulse control to avoid acting on these impulses. There is no recent history of violent or seriously destructive acts.

There may have been minor destructive behavior toward property that has not materially endangered others.

J. DRUG MEDICATION COMPLICATIONS/CO-EXISTING GENERAL MEDICAL CONDITIONS REQUIRING CARE

The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the adjustment or re-initiation of medications following discontinued use requires close observation and monitoring.

Stabilization of symptoms related to the psychiatric crisis requires adherence to a medication regimen, and compliance cannot reliably be assured (due to impaired cognition, consciousness, memory or judgment) without recurrent monitoring and supervision.

The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs.

The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.

There are concurrent physical symptoms or medical disorders that necessitate monitoring co-existing general medical conditions.

K. INTENSITY OF SERVICE

ACT services are considered medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in their community residence, to improve the beneficiary's

condition and/or allow the person to function without more restrictive care, and the person requires at least one of the following:

- Intensive and comprehensive team service, including psychiatric nursing care, provided in the beneficiary's home or community setting.

- Individualized intensity of on-site, "in vivo" services to prevent elevation of symptom acuity, to recover functional living skills and maintain or preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regimen and stabilization necessary for recovery.

- The person's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest regression, and forestall the need for inpatient care or a 24-hour protective environment.

- The person has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports.

- An intensive team-based service designed to prevent elevation of symptom acuity, to recover functional living skills, and to strengthen internal coping resources.

- Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations.

- Frequent monitoring of medication regimen and response is necessary and compliance is doubtful without ongoing monitoring and support.

- Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects.

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GENERAL INFORMATION

A clubhouse program is a community-based psychosocial rehabilitation program in which the beneficiary-members, with staff assistance, are engaged in operating all aspects of the clubhouse, including food service, clerical, reception, janitorial and other member supports and services such as employment, housing and education. In addition, members, with staff assistance, participate in the day-to-day decision-making and governance of the program and plan community projects and social activities to engage members in the community. Through the activities of the ordered day, clubhouse decision-making opportunities and social activities, individual members achieve or regain the confidence and skills necessary to lead vocationally productive and socially satisfying lives.

PROGRAM APPROVAL

Medicaid providers seeking to become providers of clubhouse psychosocial rehabilitation house services must request approval from the DCH. Departmental approval will be based on adherence to the requirements outlined below.

TARGET POPULATION

Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured program with staff and peers and have identified psychosocial rehabilitative goals that can be achieved in a supportive and structured environment. This requires that the beneficiary be able to participate in, and benefit from, the activities necessary to support the program and its members, and that the beneficiary does not have behavioral/safety or health issues that cannot adequately be addressed in a low staff-to-member program.

ESSENTIAL ELEMENTS

MEMBER CHOICE/INVOLVEMENT

- All members have access to the services/supports and resources with no differentiation based on diagnosis or level of functioning.
- Members establish their own schedule of attendance and choose a unit of the ordered day that they will regularly participate in.
- Members are actively engaged and supported on a regular basis by clubhouse staff in the activities and tasks that they have chosen.
- Membership in the program and access to supportive services reflects the beneficiary's preferences and needs.
- Both formal and informal decision-making opportunities are part of the clubhouse units and program structures so that members can influence and shape program operations.

INFORMAL SETTING

- Staff and members work side-by-side to generate and accomplish individual/team tasks and activities necessary for the development, support, and maintenance of the program.

- Members have access to the clubhouse during times other than the ordered day, including evenings, weekends, and/or holidays.

PROGRAM STRUCTURE AND SERVICES

The program's structure and schedule identifies when the various program components occur, i.e., ordered-day, vocational/educational. Other activities, such as self-help groups and social activities, shall be scheduled before and after the ordered day.

ORDERED DAY

The ordered day is a primary component of the program and provides an opportunity for members to regain self-worth, purpose, and confidence. It is made up of those tasks and activities necessary for the operation of the clubhouse and typically occurs during normal work hours. The ordered day is carried out in organizational units defined by the clubhouse that accomplish the work necessary to operate the clubhouse and meet the community living needs of the members, such as housing and transportation. Although participation in the ordered day provides opportunities to develop a variety of interpersonal and vocationally related skills, it is not intended to be job-specific training. Member participation in the ordered day provides experiences that will support members' recovery, and is designed to assist members to acquire personal, community and social competencies and to establish and navigate environmental support systems.

EMPLOYMENT SERVICES AND EDUCATIONAL SUPPORTS

Services directly related to employment, including transitional employment, supported employment, on-the-job training, community volunteer opportunities, and supports for the completion or initiation of education or training and other vocational assistance must be available.

MEMBER SUPPORTS

Opportunities for clubhouse members to provide and receive support in the community in areas of outreach, warm line, self-help groups, housing supports, entitlements, food, clothing and other basic necessities or assistance in locating community resources.

SOCIAL OPPORTUNITIES

Opportunities for members to develop a sense of a community through planning and organizing clubhouse social activities. This may also include opportunities to explore recreational resources and activities in the community. Both spontaneous and planned activities should be determined by the interests and desires of the membership.

PSYCHOSOCIAL REHABILITATION COMPONENTS

Following are some of the broad domains of psychosocial rehabilitative goals and objectives Based on the beneficiary's plan of service developed through the person-centered planning process, these are carried out during the member's participation in the ordered day and through interactions with other staff and members. Staff may also work informally with members on individual goals while working side-by-side in the clubhouse.

SYMPTOM IDENTIFICATION AND CARE

- Identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of psychological relapses.
- Gaining competence regarding how to respond to a psychiatric crisis.
- Gaining competence in understanding the role psychotropic medication plays in the stabilization of the members' well being.

COMPETENCY BUILDING

- Community living competencies (e.g., self-care, cooking, money management, personal grooming, maintenance of living environment).
- Social and interpersonal abilities (e.g., conversational competency, developing and/or maintaining a positive self-image, developing the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships).
- Personal adjustment abilities (e.g., developing and enhancing personal abilities in handling every day experiences and crisis, such as stress management, leisure time management, coping with symptoms of mental illness). The goal of this is to reduce dependency on professional caregivers and to enhance independence.
- Cognitive and adult role competency (e.g., task-oriented activities to develop and maintain cognitive abilities, to maximize adult role functioning such as increased attention, improved concentration, better memory, enhancing the ability to learn and establishing the ability to develop empathy).

ENVIRONMENTAL SUPPORT

- Identification of existing personal supports/resources for addressing personal needs (e.g., families, employers, and friends).
- Identification and development of organizational support, including such areas as sustaining personal entitlements, locating and using community resources or other supportive programs.

STAFF CAPACITY

The number of staff from the CMH should be sufficient to effectively administer the program, but also allow the members sufficient leeway to promote participation in the program. Clubhouse staff shall include:

- One full-time clubhouse manager who is a qualified professional and has extensive experience with the target population and is licensed, certified, or registered by the State of Michigan or a national organization to provide health care services. The clubhouse manager is responsible for all aspects of clubhouse operations, staff supervision and the coordination of clubhouse services with case management and ACT.
- Other experienced professional staff licensed, certified, or registered by the State of Michigan or a national organization to provide health care services.
- Other staff who are not licensed, certified, or registered by the State of Michigan to provide health care services may be part of the program, but shall operate under the supervision of a qualified professional. This supervision shall be documented.

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GENERAL INFORMATION

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis. Services may only be used to avert a psychiatric admission, or to shorten the length of an inpatient stay.

POPULATION

Services are designed for a subset of beneficiaries who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital.

COVERED SERVICES

Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiaries to allow them to return to less intensive community living as soon as possible.

The covered crisis residential services include:

- Psychiatric supervision
- Therapeutic support services
- Medication management/stabilization and education
- Behavioral services
- Milieu therapy
- Nursing services

CHILDREN CRISIS RESIDENTIAL SERVICES

Nursing services must be available through regular consultation, and must be provided on an individual basis according to the level of need of the child. Child-caring institutions providing this service must have an attestation of adherence to federal standards on the use of seclusion and restraint.

ADULT CRISIS RESIDENTIAL SERVICES

The program must include on-site nursing services (RN or LPN under appropriate supervision).

- For settings of six beds or fewer: on-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.
- For 7-16 beds: on-site nursing must be provided eight hours per day, seven days per week, with 24-hour availability on-call.

PROVIDER CRITERIA

The PHP must request approval from DCH and meet the program criteria prior to providing services.

QUALIFIED STAFF

Treatment services must be provided under the supervision of a psychiatrist. A psychiatrist need not be present when services are delivered, but must be available by telephone at all times. The program must be under the immediate direction of a professional possessing at least a bachelor's degree in a human services field, and who has at least two years work experience providing services to beneficiaries with serious mental illness.

Treatment activities may be carried out by non-degreed staff who have at least one year of satisfactory work experience providing services to beneficiaries with mental illness, or who have successfully completed a CMH/DCH-approved training program for working with beneficiaries with mental illness.

LOCATION OF SERVICES

Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size. Homes/settings must have appropriate licensure from the Michigan Department of Consumer and Industry Services and must be approved by the DCH to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting. **EXCEPTION:** Child caring institutions are permitted and may exceed 16 beds, according to the terms of their license.

ADMISSION CRITERIA

Crisis residential services may be provided to adults or children who are assessed by, and admitted through, the authority of the local PHP. Beneficiaries must meet psychiatric inpatient admission criteria but have symptoms and risk levels that permit them to be treated in such alternative settings. Services are designed for beneficiaries with mental illness or beneficiaries with mental illness **and** another concomitant disorder, such as substance abuse or developmental disabilities. For beneficiaries with a concomitant disorder, the primary reason for service must be mental illness.

DURATION OF SERVICES

Services may be provided for a period up to 14 calendar days per crisis residential episode. Services may be extended beyond 14 days and regularly monitored, if justified by clinical need, as determined by the interdisciplinary team.

INDIVIDUAL PLAN OF SERVICE

Services must be delivered according to an individual plan based on an assessment of immediate need. The plan must be developed within 48 hours of admission and signed by the beneficiary (if possible), the parent or guardian, the psychiatrist, and any other professionals involved in treatment planning, as determined by the needs of the beneficiary. If the beneficiary has an assigned case manager, the case manager must be involved in the course of treatment as soon as possible, and must also be involved in follow-up services.

The plan must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.
- Identification of the activities designed to assist the beneficiary to attain his/her goals and objectives.
- Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of, the case manager.

If the crisis period exceeds 14 days, a subsequent plan based on comprehensive assessments must be developed by an interdisciplinary team. The team is comprised of the beneficiary, the parent or guardian (if applicable), the psychiatrist, the case manager and other professionals whose disciplines are relevant to the needs of the beneficiary, including the individual ACT team, outpatient services provider or home-based services staff, when applicable. If the beneficiary did not have a case manager prior to initiation of the intensive/crisis residential service, and the crisis episode exceeds 14 days, a case manager must be assigned and involved in treatment and follow-up care. (The case manager may be assigned prior to the 14 days, according to need.)

For children's intensive/crisis residential services, the plan must also address the child's needs in context with the family's needs. Educational services must also be considered and the plan must be developed in consultation with the child's school district staff.

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GENERAL INFORMATION

Case management is a covered service that assists beneficiaries design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and supports developed through the person-centered planning process. Case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Case management services must be available for all beneficiaries with a diagnosis of a developmental disability or mental illness (including those with co-occurring substance use disorders), who have multiple service needs, have a high level of vulnerability, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

PROVIDER QUALIFICATIONS

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as evidenced by progress or achievement of goals/activities in the individual plan of service developed through person-centered planning.

DETERMINATION OF NEED

The determination of the need for case management must occur at the completion of the intake process and through the ongoing person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary's record.

CORE REQUIREMENTS

- Coordinating the person-centered planning process and, as part of this process, developing the individual plan of service. For minor children, this involves coordinating with the family through a family-centered practice approach.

- Identifying in the plan of service what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.

- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires; optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.
- Promoting the participation of the beneficiary on an ongoing basis in discussions of his or her plans, goals, and status.
- Identifying and addressing gaps in service provision.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance.
- Communicating with the beneficiary's primary and other health care providers to assure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.

ASSESSMENT

The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and safety issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.

DOCUMENTATION

The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face.

The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and safety needs). A formal review of the plan shall not occur less often than annually to measure progress toward goals and objectives and to assess beneficiary satisfaction.

MONITORING

The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) must reflect the intensity of the beneficiary's health and safety needs identified in the individual plan of services.

STAFF QUALIFICATIONS

A primary case manager must be a professional who possesses at least a bachelor's degree in a human services field typically associated with mental health services, such as social work, psychology, sociology, nursing, or occupational therapy.

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GENERAL INFORMATION

Personal care services are those services provided in accordance with an individualized plan of service to assist a beneficiary in performing his/her own personal daily activities. Services may be provided only in a licensed foster care setting with a specialized residential program certified by the Michigan Department of Consumer and Industry Services.

Personal care services are covered when ordered by a physician or a Medicaid-designated case manager, in accordance with a plan of care, and rendered by a qualified person. Supervision of personal care services may be provided by a registered nurse, physician, or case manager who meets the qualifications contained in this chapter.

SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food)
- Eating/feeding
- Toileting
- Bathing
- Grooming
- Dressing
- Transferring (between bed, chair, wheelchair, and/or stretcher)
- Ambulation
- Assistance with self-administered medications

PROVIDERS

Any provider who meets the requirements specified in the DCH/CMH specialized mental health residential services contract and has been approved by the PHP may render personal care to a Medicaid beneficiary.

DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.
- An individual plan of care that includes the specific personal care services to be delivered that is reviewed and approved at least once per year.
- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

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GENERAL INFORMATION

The PHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PHP. This means that the PHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of second opinions, and continuing stay for inpatient services, defined as follows:

Screening means the PHP has been notified of the beneficiary and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PHP personnel, or over the telephone.

Authorization/certification means that the PHP has screened the beneficiary and has approved the services requested. Telephone screening must be followed-up by the written certification.

PHP responsibilities include:

- Pre-admission screening to determine whether alternatives are appropriate and available. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day, seven-days-a-week.
- Provision of notice regarding rights to a second opinion in the case of denials per Sections 1409 and 1705 of the Mental Health Code.
- Coordination with substance abuse treatment providers, when appropriate.
- Provision of, or referral to and linkage with, alternative services, when appropriate.
- Communication with the treating and/or referring provider.
- Communication with the primary care physician or health plan.
- Planning in conjunction with hospital personnel for the beneficiary's after-care services.

In most instances, the beneficiary will receive services in a community-based psychiatric unit in the PHP service area where he/she resides. There may be instances when a PHP is responsible for a resident that they have placed into a community program in another county or state. In these cases, the responsible PHP, i.e., the one managing the case, is responsible for authorizing admission and/or continuing stay.

If a beneficiary experiences psychiatric crisis in another county, the PHP in that county should provide crisis intervention/services as needed and contact the PHP for the county of the beneficiary's residence for disposition.

ADMISSIONS

The PHPs will make authorization and approval decisions for these services according to Level of Care guidelines established by the DCH and appearing in this section. All admission and continuing stay responsibilities and procedures must be conducted in accordance with the terms of the contract between the hospital and the PHP.

BENEFICIARIES UNDER AGE 21

Pursuant to 42 CFR 441.153, certification remains required for inpatient psychiatric hospital admissions for beneficiaries under age 21. This certification is established through form MSA-4486, ("Certification of Need for Inpatient Psychiatric Services for Individuals Under Age 21") which continues to be required. PHPs are responsible for completing MSA-4486 for all elective admissions for psychiatric inpatient admission for beneficiaries under age 21. For an emergent or urgent admission, the hospital must complete the MSA-4486, in addition to obtaining admission authorization from the PHP.

FORM MSA 4486 (Front)

CERTIFICATION OF NEED FOR PSYCHIATRIC INPATIENT SERVICES FOR INDIVIDUALS UNDER AGE 21

Michigan Department of Community Health

Authority:	Title XIX of the Social Security Act
Completion:	Is Voluntary, but is required if payment from the Medical Assistance program is desired.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

SECTION I - General Information:

Patient Name	Medicaid RECIPIENT ID No.	Patient Age	Patient Birth Date

Emergency or Urgent Admission?

YES ▶ If "Yes", see **Section II** of the Instructions on the BACK of This Form.

NO ▶ If "No", please answer the next question.

Did Patient have Medicaid when Admitted?

YES ▶ If "Yes", see **Section I** of the Instructions on the BACK of This Form.

NO ▶ If "No", see **Section II** of the Instructions on the BACK of This Form.

SECTION II - CERTIFICATION TEAM INFORMATION:

- Certification of the need for psychiatric inpatient services for individuals **UNDER AGE 21** must be made by one of the teams specified on the back of this form.

Check the Type of Team Completing this Form:

1 Community Mental Health (CMH) Board OR Persons Designated by that Board.

_____
County / Board Name

2 Team Responsible for Plan of Care.

SECTION IIII - CERTIFICATION TEAM AFFIDAVIT:

We certify that:

1) Ambulatory care resources available in the community DO NOT meet the treatment needs of the recipient, **and**
2) Proper treatment of the patient's psychiatric condition requires services on an INPATIENT basis under the direction of a physician, **and**
3) The services can reasonably be expected to improve the patient's condition or prevent further regression so that the services will no longer be needed.

NOTE: All signers must be Licensed as indicated on the back of this form.

NAME (Please Print)	Degree(s)	Signature	Date
NAME (Please Print)	Degree(s)	Signature	Date
NAME (Please Print)	Degree(s)	Signature	Date

MSA-4486 (Rev. 3-98) Previous edition may be used

COPY DISTRIBUTION: PART 1 (White) - Must be retained in patient hospital records.
PART 2 (Yellow) - Must be retained by CMH Boards:
Elective admissions by certifying boards.
Emergency or urgent admissions by local boards

Exhibit: MSA 4486 FRONT

MSA-4486 (Back)

INSTRUCTIONS FOR CERTIFICATION
(form MSA-4486)

SECTION 1:

For elective Medicaid admissions, certification must be made by an independent team (CMH Board or persons designated by the CMH board) that:

1) Includes a physician licensed to practice medicine or osteopathy, **and**
2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, **and**
3) Has knowledge of the individual's situation.

SECTION II :

For emergency or urgent admissions or for persons who become Medicaid eligible after admission, certification must be made by the team responsible for the plan of care. It must cover any period before the date is completed for which Medicaid reimbursement claims are made, i.e., certifying statements must be true of the entire claim period. Emergency and urgent admissions must be certified within 14 days after the admission.

The certifying team must be capable of:

1) Assessing the recipient's immediate and long range therapeutic needs, developmental priorities, and personal strengths and liabilities, **and**
2) Assessing the potential resources of the recipient's family, **and**
3) Setting treatment objectives, **and**
4) Prescribing therapeutic modalities to achieve the plan's objectives.

The certifying team must include, as a minimum, professionals described in both categories A and B below.

A. 1) A Board-eligible or Board-certified psychiatrist, **or**

2) Both a licensed clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy, **or**

3) Both a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a licensed psychologist who has a master's degree in clinical psychology.

B. 1) A psychiatric social worker with an MSW degree, **or**

2) A registered nurse with specialized training or one year's experience in treating mentally ill individuals, **or**

3) An occupational therapist who is licensed by the State and who has specialized training or one year of experience in treating mentally ill individuals, **or**

4) A licensed psychologist who has a master's degree in clinical psychology.

MSA-4486 (Rev. 3-98) (BACK)

Exhibit: MSA 4486 BACK

EMERGENCY ROOM SERVICES

When necessary, the beneficiary may seek services through the emergency room. Disposition of the psychiatric emergency will be the responsibility of the PHP and may result in:

- inpatient admission,
- referral to an alternative service when appropriate and available, or
- disposition of the crisis through provision of immediate services/interventions, with follow-up as necessary.

The PHP is involved in the psychiatric aspect of the emergency situation. Any medical treatment needed by the beneficiary is beyond the general purview of the PHP.

ADMISSIONS TO IN-STATE OUT-OF-AREA HOSPITALS

Medicaid beneficiaries may seek inpatient psychiatric services from hospitals located outside their county of residence/PHP catchment area. If the out-of-area hospital has a contract with the beneficiary's county/catchment area PHP, the hospital should contact that PHP to obtain the required pre-admission authorization/approval for the beneficiary. If the out-of-area hospital does not have a contract with the beneficiary's designated county/catchment area PHP, the hospital must contact the PHP that serves the county in which the hospital is located to obtain pre-admission approval/authorization. The hospital-area PHP will conduct the pre-admission review and will consult with the designated county/catchment area PHP to determine the appropriate disposition of the request for admission authorization/approval. Payment responsibility for authorized days of care will rest with the PHP that authorized the services.

ADMISSION TO OUT-OF-STATE NON-BORDERLAND INPATIENT PSYCHIATRIC HOSPITALS

The PHP for the beneficiary's county of residency must prior authorize the admission for psychiatric inpatient care as medically necessary, as with in-state hospitals. The PHP is responsible for continued stay reviews and payment to these hospitals.

APPEALS

PHPs will make authorization and approval decisions for services according to Level of Care guidelines. If the hospital disagrees with the decision of the PHP, regarding either admission authorization/approval or the number of authorized days of care, the hospital may appeal to the PHP according to the terms of its contract with the PHP. If the hospital does not have a contract or agreement with the PHP, any appeals by the hospital will be conducted through the usual and customary procedures that the PHP employs in its contracts with enrolled hospital providers.

If a beneficiary or his/her legal representative disagrees with a PHP decision related to admission authorization/approval or approved days of care, he/she may request a reconsideration and second opinion from the PHP. If the PHP's initial decision is upheld, the beneficiary has further redress through the Medicaid fair hearing process. Medicaid beneficiaries can request the Medicaid fair hearing without going through local review processes.

BENEFICIARIES WHO DO NOT HAVE MEDICAID ELIGIBILITY UPON ADMISSION

For beneficiaries whose enrollment in Medicaid is determined after the end of an episode of inpatient psychiatric or partial hospitalization care (eligibility extends back and encompasses the dates of the episode of care), the PHP will conduct a retrospective review of the episode of care to determine if services were medically necessary and appropriate for Medicaid reimbursement, unless the PHP has previously reviewed and certified the admission and authorized days of care under other contractual and payment arrangements with the hospital. If the PHP has conducted the pre-admission authorization and continuing stay reviews for these beneficiaries during the episode of care, this will be considered as a certification that authorized services are eligible for reimbursement by the PHP under the Medicaid program once the beneficiary's retroactive Medicaid eligibility has been established.

As noted above, the purpose of a retrospective review is to determine if services rendered were medically necessary and hence qualify for Medicaid reimbursement. Since the hospital will not receive reimbursement for any care rendered which does not meet the test of medical necessity, it is advantageous for hospitals to involve PHPs during the episode of care for any beneficiary that the facility believes may be eligible for Medicaid.

MEDICARE

For Medicare-covered services, DCH will only pay up to a Medicare-enrolled beneficiary's obligation to pay (i.e., co-insurance and deductibles). This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare.

LEVEL OF CARE GUIDELINES – UTILIZATION MANAGEMENT CRITERIA

INPATIENT PSYCHIATRIC AND PARTIAL HOSPITALIZATION SERVICES

INTRODUCTION

The Medicaid Program requires that hospitals providing inpatient psychiatric services (provider types 68 and 73) or partial hospitalization services (provider types 41 and 75) obtain authorization and certification of the need for admission and continuing stay from Prepaid Health Plans (PHPs). Authorization and certification are based upon a determination by a PHP reviewer, applying criteria outlined in this document. The hospital or attending physician may request a reconsideration of adverse authorization/certification determinations made by the initial PHP reviewer.

The criteria described below employ the concepts of **Severity of Illness (SI)** and **Intensity of Service (IS)** to assist reviewers in determinations regarding whether a particular care setting or service intensity is appropriately matched to the beneficiary's current condition. Severity of Illness refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the beneficiary's psychiatric disorder. Intensity of Service (IS) refers to the setting of care, to the types and frequency of needed services and supports, and to the degree of restrictiveness necessary to safely and effectively treat the beneficiary.

Medicaid coverage for inpatient psychiatric services is limited to beneficiaries with a current primary psychiatric diagnosis, as described in the criteria below. It is recognized that some beneficiaries will have other conditions or disorders (e.g., developmental disabilities or substance use) that co-occur with

a psychiatric disturbance. In regard to developmental disabilities, if a person with developmental disabilities presents with signs or symptoms of a significant, serious, concomitant mental illness, the mental illness will take precedence for purposes of care and placement decisions, and the beneficiary may be authorized/certified for inpatient psychiatric care under these guidelines.

For beneficiaries who present with psychiatric symptoms associated with current active substance abuse, it may be difficult to determine whether symptoms exhibited are due to a primary mental illness or represent a substance-induced disorder, and to make an informed level of care placement decision. A beneficiary exhibiting a psychiatric disturbance in the context of current active substance use or intoxication may require acute detoxification services before an accurate assessment of the need for psychiatric inpatient services can be made. In these situations, the hospital and the PHP must confer to determine the appropriate location (acute medical setting or psychiatric unit) for the detoxification services.

The crucial consideration in initial placement decisions for a beneficiary with psychiatric symptoms associated with current active substance abuse is whether the beneficiary's immediate treatment needs are primarily medical or psychiatric. If the beneficiary's primary need is medical (e.g., life-threatening substance-induced toxic conditions requiring acute medical care and detoxification), then detoxification in an acute medical setting (presuming the beneficiary's condition meets previously published acute care detoxification criteria) is indicated. If the beneficiary's primary need is psychiatric care (the person meets the SI/IS criteria for inpatient psychiatric care), then they should be admitted to the psychiatric unit and acute medical detoxification provided in that setting.

Hospitals are reminded that they must obtain PHP admission authorization and certification for all admissions to a distinct psychiatric unit or freestanding psychiatric hospital.

INPATIENT ADMISSION CERTIFICATION CRITERIA: ADULTS

GENERAL JUSTIFICATION

Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically-structured and -supervised facility. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA (Must meet <u>all</u> three)

A. Diagnosis

The beneficiary must be suffering from a mental illness, reflected in a primary, validated, DSM-IV Axis I, or ICD-9 Diagnosis (not including V Codes).

B. **Severity of Illness** (signs, symptoms, functional impairments and risk potential)

At least one of the following manifestations is present:

1. Severe psychiatric signs and symptoms
2. Serious disruptions of self-care, inability to attend to basic physical needs, grave and disabling impairments in interpersonal functioning, and/or severe deterioration in educational/occupational role performance
3. Harm to self
4. Harm to others
5. Drug/medication complications and/or significant co-existing general medical condition which needs to be simultaneously addressed, along with the psychiatric illness, and which cannot be carried out at a less intensive level of care or in another medical setting.

1. Severe Psychiatric Signs and Symptoms

- Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
- Disorientation, seriously impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
- A severe, life-threatening psychiatric syndrome or an atypical or unusually complex psychiatric condition exists that has failed, or is deemed unlikely, to respond to less intensive levels of care, and has resulted in substantial current dysfunction.

2. Disruptions of Self-Care and Independent Functioning

- The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to psychiatric disorder.
- There is evidence of serious disabling impairment in interpersonal functioning (e.g., withdrawal from relationships; repeated conflictual interactions with family, employer, co-workers, neighbors) and/or extreme deterioration in the person's ability to meet current educational/occupational role performance expectations.

3. Harm to Self

- Suicide: Attempt or ideation is considered serious by the intentionality, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgment, psychological symptoms), history of prior attempts, and/or existence of a workable plan.
- Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.

- Other Self-Injurious Activity: The person has a recent history of drug ingestion with a strong suspicion of overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.

4. Harm to Others

- Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.
- There is expressed intention to harm others and a plan and/or means to carry it out, and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgment, or psychological symptoms, such as persecutory delusions and paranoid ideation).
- There has been significant destructive behavior toward property that endangers others.

5. Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care

- The person has experienced severe side effects from using therapeutic psychotropic medications.
- The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
- There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

Special Consideration: Concomitant Substance Abuse

- The underlying or existing psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment is necessary in the psychiatric unit or hospital setting.

C. Intensity of Service

The person meets the intensity of service requirements if inpatient services are considered medically necessary for the beneficiary's treatment/diagnosis, and if the person requires at least one of the following:

1. Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.

2. Close and continuous skilled medical observation is necessary due to otherwise unmanageable side effects of psychotropic medications.

3. Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) is needed to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.

4. A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to the complexity and/or the severity of the beneficiary's signs and symptoms.

INPATIENT ADMISSION CERTIFICATION CRITERIA: CHILDREN THROUGH AGE 21

GENERAL JUSTIFICATION

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically-structured and -supervised facility. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission are based on the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA (Must meet all three)

A. Diagnosis

The beneficiary must be suffering from a mental illness, reflected in a primary, validated, DSM-IV Axis I, or ICD-9 Diagnosis (not including V Codes).

B. Severity of Illness (signs, symptoms, functional impairments and risk potential)

At least one of the following manifestations is present:

- Severe psychiatric signs and symptoms
- Serious disruptions of self-care and/or severely and pervasively impaired personal adjustment, demonstrated in behavior or dysfunction symptomatic of that impairment
- Harm to self
- Harm to others
- Drug/medication complications and/or significant co-existing general medical condition which needs to be simultaneously addressed along with the psychiatric illness and which cannot be carried out at a less intensive level of care or in another medical setting.

1. Severe Psychiatric Signs and Symptoms

- Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
- Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.

- Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction.

2. Disruption of Self-Care/Support or Severely Impaired Personal Adjustment

   - Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder.
   - The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance.

3. Harm to Self

   - A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, impulsivity.
   - There is a specific plan to harm self with clear intent and/or lethal potential.
   - There is self-harm ideation or threats without a plan which are considered serious due to impulsivity, current impairment or a history of prior attempts.
   - There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior.
   - There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
   - There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.

4. Harm to Others

   - Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.
   - There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired.
   - There has been significant destructive behavior toward property that endangers others, such as setting fires.

5. Drug/Medication Complications or Co-Existing General Medical Condition Requiring Care

   - The person has experienced severe side effects from using therapeutic psychotropic medications.
   - The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
   - There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric

hospitalization, and the co-existing general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care.

Special Consideration: Concomitant Substance Abuse

- The underlying psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.

C. **Intensity of Service**

The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least one of the following:

1. Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications.

2. Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications.

3. Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur.

4. A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

INPATIENT PSYCHIATRIC CARE – CONTINUING STAY CERTIFICATION: ADULTS, ADOLESCENTS AND CHILDREN

RECERTIFICATION RATIONALE

After a beneficiary has been certified for admission to an inpatient psychiatric setting, services will be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the patient's problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations or biologic/medication complications, similar to those which justified the patient's admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the inpatient unit. **Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.**

CRITERIA (Must meet all three)

A. Diagnosis

The beneficiary has a validated DSM-IV Axis I or ICD-9 mental disorder (excluding V codes) which remains the principal diagnosis for purposes of care during the period under review.

B. Severity of Illness

- Persistence/intensification of signs/symptoms, impairments, harm inclinations or biologic/medication complications which necessitated admission to this level of care, and *which cannot currently be addressed at a lower level of care.*
- Continued severe disturbance of cognition, perception, affect, memory, behavior or judgment.
- Continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment.
- Continued significant self/other harm risk.
- Use of psychotropic medication at dosage levels necessitating medical supervision, dosage titration of medications requiring skilled observation, or adverse biologic reactions requiring close and continuous observation and monitoring.
- Emergence of new signs/symptoms, impairments, harm inclinations or medication complications, meeting admission criteria.

C. Intensity of Service

- The beneficiary requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, to assure basic needs are met or to manage biologic/medication complications.
- The beneficiary is receiving active, timely, treatment delivered according to an individualized plan of care.
- Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to inpatient care.
- The beneficiary is making progress toward treatment goals as evidenced by a measurable reduction in signs/symptoms, impairments, harm inclinations or biologic/medication complications or, if no progress has been made, there has been a modification of the treatment plan and therapeutic program, and there is a reasonable expectation of a positive response to treatment.
- Discharge criteria and aftercare planning are documented in the beneficiary's record.

GENERAL INFORMATION

The PHP is responsible for authorizing and paying for Medicaid admissions and continued stays in partial hospitalization programs by Medicaid beneficiaries.

- Admissions - beneficiaries may be referred to a partial hospitalization program from either psychiatric inpatient hospitals or psychiatric units, referring providers, or PHPs, or they may present themselves at the outpatient hospital without a referral.
- Continued stays are to be authorized by the PHP.

Authorization for the partial hospitalization admission and continued stay includes authorization for all services related to that admission/stay. This includes laboratory, pharmacy, and radiology services. The outpatient partial hospitalization program must bill the PHP for authorized services according to procedures and rates established between the hospital and the PHP.

PARTIAL HOSPITALIZATION ADMISSION CERTIFICATION CRITERIA: ADULTS

GENERAL JUSTIFICATION

Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in either self-care, daily living skill, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA (Must meet all three)

A. Diagnosis

The beneficiary must be suffering from a mental illness, reflected in a primary, validated, DSM-IV or ICD-9 Diagnosis (not including V Codes).

B. Severity of Illness (signs, symptoms, functional impairments and risk potential)

At least two of the following manifestations are present:

- Psychiatric signs and symptoms (psychotic or non-psychotic clinical characteristics which suggest a significant pathological condition)

- Serious disruption of pre-existing self-care skills; diminished ability to attend to basic physical needs or to perform daily living skills; deterioration in interpersonal functioning; difficulties meeting familial/social and/or educational/occupational role performance expectations
- Moderate danger to self
- Moderate danger to others
- Drug/medication regimen complications

1. Psychiatric Signs and Symptoms

   - Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation is not so severe, extreme or unstable so as to require frequent restraints or to pose a danger to others.

2. Disruptions of Self-Care and Independent Functioning

   - The person seriously neglects self-care tasks (hygiene, grooming, etc.) and/or does not sufficiently attend to essential aspects of daily living (doesn't shop, prepare meals, maintain adequate nutrition, pay bills, complete housekeeping chores, etc.) due to a mental disorder.
   - Beneficiary is able to maintain adequate nutrition, shelter or other essentials of daily living only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.
   - The person's interpersonal functioning is significantly impaired (seriously dysfunctional communication, extreme social withdrawal, etc.).
   - There has been notable recent deterioration in meeting educational/occupational responsibilities and role performance expectations.

3. Danger to Self

   - There is modest danger to self reflected in intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, mild and infrequent self-harm gestures (low lethality/intent) or self-mutilation, passive death wishes, or slightly self-endangering activities.
   - The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity **or**, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

4. Danger to Others

   - Where assaultive tendencies exist, there have been no overt actions and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb these inclinations.
   - There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.
   - There has been minor destructive behavior toward property without endangerment of others.

5. Drug/Medication Complications

   - The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs, and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
   - The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.

C. Intensity of Service

The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least one of the following:

1. The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care.

2. The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments.

3. Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

PARTIAL HOSPITALIZATION ADMISSION CRITERIA: CHILDREN AND ADOLESCENTS

GENERAL JUSTIFICATION

Partial hospitalization services may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week, in a licensed setting. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission assume that the beneficiary is displaying signs and symptoms of a

serious psychiatric disorder, demonstrating significant functional impairments in either self-care, daily living skill, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) does not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

CRITERIA (Must meet all three)

A. Diagnosis

The beneficiary must be suffering from a mental illness, reflected in a primary, validated, DSM-IV or ICD-9 Diagnosis (not including V Codes).

B. Severity of Illness (signs, symptoms, functional impairments and risk potential)

At least two of the following manifestations are present:

- Psychiatric signs and symptoms (psychotic or non-psychotic clinical characteristics which suggest a significant pathological condition)
- Serious disruption/incapacitation of self-care skills; diminished ability to attend to age-appropriate responsibilities; deterioration in interpersonal functioning; difficulties meeting familial/social and/or educational role performance expectations
- Moderate danger to self
- Moderate danger to others
- Drug/medication regimen complications

1. Psychiatric Signs and Symptoms

- Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation is not so severe, extreme or unstable so as to require frequent restraints or to pose a danger to others.

2. Disruptions of Self-Care and Independent Functioning

- The child/adolescent exhibits significant impairments in self-care skills (feeding, dressing, toileting, hygiene/bathing/grooming, etc.), in the ability to attend to age-appropriate responsibilities, or in self-regulation capabilities, due to a mental disorder or emotional illness.

- The child/adolescent is able to maintain adequate self-care and self-regulation only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.
- There is recent evidence of serious impairment/incapacitation in the child's/adolescent's interpersonal and social functioning (seriously dysfunctional communication, significant social withdrawal and isolation, repeated disruptive, inappropriate or bizarre behavior in social settings, etc.).
- There is recent evidence of considerable deterioration in functioning within the family and/or significant decline in occupational/educational role performance due to a mental disorder or emotional illness.

3. Danger to Self

- There is modest danger to self reflected in: non-accidental self-harm gestures or self-mutilation actions which are not life-threatening in either intent or lethal potential; intermittent self-harm ideation; expressed ambivalent inclinations without a plan; non-intentional threats; passive death wishes, or slightly self-endangering activities.
- The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity **or**, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

4. Danger to Others

- Assaultive tendencies exist, and some assaultive behavior may have occurred, but any overt actions have been without any serious or significant injury to others, and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb any serious expression of these inclinations.
- There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have adequate impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.
- There has been minor destructive behavior toward property without endangerment of others.

5. Drug/Medication Complications

- The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved.
- The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.

C. Intensity of Service

The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least one of the following:

1. The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care.

2. The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive, treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments.

3. Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

PARTIAL HOSPITALIZATION CONTINUING STAY CERTIFICATION CRITERIA FOR ADULTS, ADOLESCENTS AND CHILDREN

RECERTIFICATION RATIONALE

After a beneficiary has been certified for admission to a partial hospitalization program, services will be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in a partial hospitalization setting. Treatment within a partial hospitalization program is directed at resolution or stabilization of acute symptoms, elimination or amelioration of disabling functional impairments, maintenance of self/other safety and/or regulation of precarious or complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the partial program remains the most appropriate, least restrictive, level of care for treatment of the patient's problems and dysfunctions.

Continuing treatment in the partial program may be certified when symptoms, impairments, harm inclinations or medication complications, similar to those which justified the patient's admission certification, remain present, and continue to be of such a nature and severity that partial hospitalization treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the program. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

CRITERIA (Must meet <u>all</u> three)

A. Diagnosis

The beneficiary has a validated DSM-IV or ICD-9 mental disorder (excluding V Codes), which remains the principal diagnosis for purposes of care during the period under review.

B. Severity of Illness

- Persistence of symptoms, impairments, harm inclinations or medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care.

- Emergence of new symptoms, impairments, harm inclinations or medication complications meeting admission criteria.
- Progress has been made in ameliorating admission symptoms or impairments, but the treatment goals have not yet been fully achieved and cannot currently be addressed at a lower level of care.

C. Intensity of Service

- The beneficiary is receiving active, timely, intensive, structured multi-modal treatment delivered according to an individualized plan of care.
- Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or medication complications that necessitated admission to the program.
- The beneficiary is making progress toward treatment goals or, if no progress has been made, the treatment plan and therapeutic program have been revised accordingly and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the beneficiary's record.

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GENERAL INFORMATION

Intensive/crisis stabilization services are structured treatment and support activities provided by a mental health crisis team and designed to provide a short-term alternative to inpatient psychiatric services. Services may only be used to avert a psychiatric admission or to shorten the length of an inpatient stay.

The standard for whether or not a mental health emergency exists is a "prudent layperson" standard. That means a prudent layperson must be able to determine from the beneficiary's symptoms that intensive crisis services are necessary.

PROGRAM APPROVAL

Medicaid providers wishing to become providers of intensive/crisis services must request the approval from DCH and meet the program components outlined below.

POPULATION

These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.

Beneficiaries must have a diagnosis of mental illness or mental illness with a co-occurring substance use disorder or developmental disability.

SERVICES

Intensive/crisis services are intensive treatment interventions delivered by an intensive/crisis stabilization treatment team, under psychiatric supervision. Component services include:

- Intensive individual counseling/psychotherapy
- Assessments (rendered by the treatment team)
- Family therapy
- Psychiatric supervision
- Therapeutic support services by trained paraprofessionals

QUALIFIED STAFF

Intensive/crisis services must be provided by a treatment team of professionals under the supervision of a psychiatrist. The psychiatrist need not provide on-site supervision at all times, but must be available by telephone at all times. Professionals providing intensive/crisis stabilization services must be health care professionals. Nursing services/consultation must be available.

The professional treatment team may be assisted by trained paraprofessionals under appropriate supervision. The trained paraprofessionals must have at least one year of satisfactory work experience providing services to beneficiaries with serious mental illness OR have completed a CMH/DCH -

approved training program for working with beneficiaries with mental illness. Activities of the trained paraprofessionals include assistance with therapeutic support services.

LOCATION OF SERVICES

Intensive/crisis stabilization services may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, his/her usual community environment.

Exceptions: Intensive/crisis stabilization services may NOT be provided in:

- Inpatient settings
- Jails or other settings where the beneficiary has been adjudicated
- Crisis residential settings

INDIVIDUAL PLAN OF SERVICE

Intensive/crisis stabilization services may be provided initially to alleviate an immediate or serious psychiatric crisis. However, following resolution of the immediate situation (and within no more than 48 hours), an intensive/crisis stabilization services treatment plan must be developed. The intensive/crisis stabilization treatment plan must be developed by the professionals on the treatment team in consultation with the psychiatrist and the beneficiary/guardian. Other professionals may also be involved if required by the needs of the beneficiary. The case manager (if the beneficiary receives case management services) must be involved in the treatment and follow-up services.

The individual plan of service must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, and stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.
- Identification of the services and activities designed to resolve the crisis and attain his/her goals and objectives.
- Plans for follow-up services (including other mental health services where indicated) after the crisis has been resolved. The role of the case manager must be identified, where applicable.

For children's intensive/crisis stabilization services, the treatment plan must also address the child's needs in context with the family needs. Educational services must also be considered and the treatment plan must be developed in consultation with the child's school district staff.

GENERAL INFORMATION

Beneficiaries with developmental disabilities who are approved for enrollment in Michigan's Habilitation/Supports Waiver (HSW) receive the supports and services as defined in this section. The HSW beneficiaries may also receive other Medicaid services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Service selection guidelines for beneficiaries with developmental disabilities should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PHP must be specified in his/her individual plan of services developed through the person-centered planning process.

Habilitation/Supports Waiver beneficiaries must be enrolled through the DCH enrollment process. The enrollment process must include annual verification that the beneficiary:

- meets Intermediate Care Facility for Mental Retardation (ICF/MR) level of care requirements; and
- chooses to participate in the Habilitation/Supports Waiver in lieu of ICF/MR services.

The enrollment process also includes confirmation of changes in the beneficiary's enrollment including termination from the waiver, movement between PHPs, and deaths. Instructions for beneficiary enrollments and annual verification may be obtained from the DCH, Bureau of Mental Health and Substance Abuse Services.

The PHP shall employ a prudent purchase principle when considering the purchase or direct provision of services and supports. Prudent purchase is a combination of quality and cost, where quality is measured by the ability to meet the beneficiary's need and cost is measured by being the most reasonable and economical approach necessary to meet that need. The PHP shall assist beneficiaries to examine their first- and third-party resources, to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PHP covered activities, supports or services. It is recommended that the PHP prior authorize, in writing, any purchase of equipment, supplies or environmental modification. The service provided shall be the most reasonable alternative, based on a review of all the options.

Reimbursement for services rendered under the Habilitation/Supports Waiver is included in the CMH's capitation rate.

WAIVER SUPPORTS AND SERVICES

CHORE SERVICES

Services to maintain the home in a clean, sanitary, and safe environment, including:

- Heavy household chores such as washing walls, floors and exterior windows.
- Tacking down loose rugs and tiles
- Moving heavy furniture in order to provide safe mobility within the home
- Removing snow to provide safe access to, and egress from, the home.

These services should be provided by persons not routinely providing other direct waiver supports and services, and only in cases where neither the beneficiary, nor anyone else in the household, is capable of performing or financially providing for them. In the case of rental property, the responsibility of the landlord, pursuant to the rental or lease agreement, must be examined prior to authorization of the service. This service may not be provided to beneficiaries who live in licensed settings because the activities are the responsibility of the home's licensee.

COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) facilitate an individual's independence and promote integration into the community. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings. The supports are:

- Reminding, observing, guiding or training the beneficiary with:
  - Meal preparation
  - Laundry
  - Routine household care and maintenance
  - Activities of daily living, such as bathing, eating, dressing, personal hygiene
  - Shopping
- Assistance, support and/or training the beneficiary with:
  - Money management
  - Reminding, observing, and/or monitoring of medications
  - Non-medical care (not requiring nurse or physician intervention)
  - Socialization and relationship building
  - Transportation*
  - Leisure choice and participation in regular community activities
  - Attendance at medical appointments

The CLS do not include the costs associated with room and board. Payment for CLS does not include payments made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children).

The Habilitation/Support Waiver services cannot supplant Medicaid services. The beneficiary who resides in an unlicensed setting must use the Family Independence Agency Home Help or Enhanced Home Help services for assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living (bathing, eating, dressing, personal hygiene), and shopping.

*Transportation to medical appointments is covered by Medicaid.

ENHANCED DENTAL

Accepted dental procedures that are not available to adults (over 21) under regular Medicaid dental coverage; provided to beneficiaries with dental problems sufficient to lead to more generalized disease due to infection or improper nutrition which would require institutionalization. Common conditions that would qualify for these procedures include:

- Congenital deformities of the mid-face, palate, maxilla, and mandible.
- Multiple recurrent cavities due to the person's inability to maintain optimal oral hygiene.
- Chronic periodontal disease secondary to medications and/or the person's inability to maintain oral hygiene.
- Chronic pain interfering with the ability to chew and swallow.
- Chronic abscess formation.
- Other unique conditions that would lead to infection and/or nutritional deficiency if not otherwise corrected.

ENHANCED MEDICAL EQUIPMENT AND SUPPLIES

Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverages or through other insurances. All enhanced medical equipment and supplies must be specified in the plan of supports and services, and must enable the beneficiary to increase his/her abilities to perform activities of daily living; or to perceive, control, or communicate with the environment. Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the beneficiary, are excluded from coverage. "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service. "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal.

The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be prescribed by a physician. This coverage includes:

- Adaptations to vehicles
- Items necessary for life support
- Ancillary supplies and equipment necessary for proper functioning of such items

Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services.

Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home are not included.

Items that are considered family recreational choices are not covered. The purchase of a vehicle and any repairs or routine maintenance to the vehicle are not covered. Educational supplies are expected to be provided by the school and are not covered.

Covered items shall meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PHP should provide written authorization prior to purchase of equipment and supplies.

Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PHP must provide evidence of training in the use of the equipment to prevent future incidents.

ENHANCED PHARMACY

Physician-ordered, nonprescription "medicine chest" items as specified in the person's support plan. Items that are not of direct medical or remedial benefit to the beneficiary are not allowed. Allowable items include the following:

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
- Vitamins and minerals
- First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)
- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes)
- Special tweezers and nail clippers that accommodate the person's disability (e.g., reachers, or longer, wider handles)

Products or prostheses necessary to ameliorate negative visual impact of serious facial disfigurements (e.g., absence of ear, nose, or other feature or massive scarring) and/or skin conditions (including exposed area eczema, psoriasis, or/or acne) are included.

Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products) are not included.

ENVIRONMENTAL MODIFICATIONS

Physical adaptations to the home and/or workplace required by the beneficiary's support plan that are necessary to ensure the health, safety, and welfare of the beneficiary, or enable him/her to function with greater independence within the environment(s) and without which the beneficiary would require institutionalization.

Adaptations may include:

- The installation of ramps and grab bars
- Widening of doorways
- Modification of bathroom facilities

- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary

Adaptations or improvements to the home that are not of direct medical or habilitative benefit to the beneficiary (e.g., carpeting and roof repair) are not included.

"Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be prescribed by a physician.

Central air-conditioning is included only when prescribed by a physician and specified with extensive documentation in the support plan as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.

The PHP must assure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PHP to work with the beneficiary and builder to ensure that the work is completed as outlined in the contract and that issues are resolved between all parties.

The environmental modification must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance. Environmental modifications shall exclude costs for improvements exclusively required to meet local building codes.

The environmental modification must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

The environmental modification must demonstrate cost-effectiveness. The beneficiary must apply to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the beneficiary's records. The HSW is a funding source of last resort.

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of beneficiary and are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air-conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs. Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a beneficiary's home. Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves and must indicate that the HSW and the DCH are not obligated for any restoration costs.

If a beneficiary purchases or builds a home while receiving waiver services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. The HSW does not cover construction costs in a new home, or a home purchased after the beneficiary is enrolled in the waiver. HSW funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, etc.) for a home recently purchased.

Environmental modifications for **licensed settings** includes only the remaining balance of previous environmental modification costs that accommodate the specific needs of current waiver beneficiaries, and will be limited to the documented portion being amortized in the mortgage, or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or to meet local building codes.

Adaptations to the **work environment** are limited to those necessary to accommodate the person's individualized needs, and cannot be used to supplant the requirements of Section 504 of the Rehabilitation Act or the Americans with Disabilities Act.

All services must be provided in accordance with applicable state or local building codes. It is recommended that the PHP provide written authorization prior to contracting.

Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as a part of the cost of the service.

FAMILY TRAINING

Training and counseling services for the families of beneficiaries served on the waiver. For purposes of this service, "family" is defined as the family members who live with or provide care to the beneficiary in the Habilitation/Supports Waiver, and may include parent, spouse, children, relatives, foster family, or in-laws.

Training includes instructions about treatment regimens and use of equipment specified in the individual plan of services, and includes updates as needed to safely maintain the person at home. Family training goals, and the content, frequency, and duration of the training and/or counseling, should be identified in the beneficiary's individual plan of services.

Not included are individuals who are employed to care for the beneficiary.

OUT-OF-HOME NON-VOCATIONAL HABILITATION

Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the person resides.

Examples of incidental support include:

- Aides helping the beneficiary with his/her mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community.

- When necessary, helping the person to engage in the habilitation activities (e.g., interpreting).

Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services.

These supports focus on enabling the person to attain or maintain his/her maximum functioning level, and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

Electronic devices that enable beneficiaries to secure help in the event of an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once the button is activated.

PERS coverage should be limited to beneficiaries living alone, or who are alone for significant parts of the day; who have no regular support or service provider for those parts of the day; and who would otherwise require extensive routine support and guidance.

PREVOCATIONAL SERVICES

Services aimed at preparing a beneficiary for paid or unpaid employment, but that are not job task-oriented. They include teaching such concepts as compliance, attendance, task completion, problem solving, and safety. Prevocational services are provided to people not expected to be able to join the general workforce, or to participate in a transitional sheltered workshop within one year (excluding supported employment programs). Transportation provided between the beneficiary's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services.

Activities included in these services are primarily directed at reaching habilitative goals, such as improving attention span and motor skills, not at teaching specific job skills. These services must be reflected in the person's individual plan of service and directed to habilitative objectives rather than employment objectives. When compensated, beneficiaries are paid at less than 50 percent of the minimum wage.

This service must not otherwise be available to the beneficiary through the Rehabilitation Act of 1973, or Education of the Handicapped Act (P.L. 94-142). Documentation must be maintained by the PHP that the beneficiary is not currently eligible for work activity or supported employment services provided by Michigan Rehabilitation Services (MRS). Information must be updated when MRS eligibility conditions change.

PRIVATE DUTY NURSING

HSW enhanced private duty nursing services consist of nursing procedures that are medically necessary to meet those of the enrolled beneficiary's health needs which are directly related to his or her developmental disability. Medically necessary is defined as a finding that the beneficiary meets the criteria of either I. and III. listed below, or II. and III. listed below. **NOTE:** Private Duty Nursing is a

Medicaid coverage for beneficiaries under age 21 who meet the medical criteria for eligibility and, therefore, private duty nursing services covered by this waiver are not available to that age group.

I. The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

- Mechanical ventilation four or more hours per day or assisted respiration (Bi-PAP or CPAP); or
- Oral or tracheostomy suctioning eight or more times in a 24-hour period; or
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
- Continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.

II. Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions (as described in III. Below) due to a substantiated progressively debilitating physical disorder.

Definitions:

- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.
- "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder. The requirement for frequent episodes of medical instability is applicable only to the initial determination for private duty nursing. A determination of need for continued private duty nursing services is based on the continuous skilled nursing care (defined in III. below).
- "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- "Progressively debilitating physical disorder" means an illness, diagnosis, or syndrome that results in increasing loss of function due to a physical disease process, and that has progressed to the point that continuous skilled nursing care (as defined in III. below) is required.
- "Substantiated" means documented in the clinical/medical record, including the nursing notes.

III. The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions:

- "Continuous" means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.

Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

These services should be provided to a beneficiary at home or in the community. A physician's prescription is required.

The PHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

RESPITE CARE

Respite is intended for beneficiaries whose primary caregivers typically are the same people day after day (e.g., family members and/or adult family foster care providers), and is provided during those portions of the day when the caregivers typically provide care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes, and not by respite care.

Respite care services are provided on a short-term basis because of the absence or need for relief of those persons normally providing the care of a waiver beneficiary. Respite care may be provided in the following settings:

- Waiver beneficiary's home or place of residence.
- Licensed foster care home.
- Facility approved by the State that is not a private residence, such as:
  - Group home
  - Licensed respite care facility
- Home of a friend or relative (not the parent of a minor child or the spouse of the beneficiary served) chosen by the beneficiary and members of the planning team (including staff providing supports coordination).

Cost of room and board must not be included as part of the respite care **unless** provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/MR, nursing facility, or hospital) is not covered by the Habilitation/Supports Waiver.

SUPPORTS COORDINATION

Supports coordination involves working with the waiver beneficiary, and others that are identified by the beneficiary such as family member(s), in developing a written individual plan of services through the person-centered planning process or for minor children, through a family-centered practice approach. Using person-centered processes (including planning), support coordination assists in identifying and implementing support strategies. Supports strategies incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Support coordinators work closely with the beneficiary to assure his/her ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports coordination means face-to-face and related contacts, including activities, that assure:

- The desires and needs of the beneficiary are determined
- The supports and services desired and needed by the beneficiary are identified and implemented
- Housing and employment issues are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided
- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored
- Income/benefits are maximized
- Activities are documented
- Individual plans of supports/services are revi ewed at such intervals as are indicated during planning

Additionally, the supports coordinator coordinates with the qualified mental retardation professional (QMRP) on the process of initial waiver eligibility certification and annual re-certification.

Supports coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Habilitation Education Services, Prevocational Services, Supported Employment, or CLS. While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverages and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The frequency and scope of supports coordination contacts must be relevant to the health and safety needs of the beneficiary.

SUPPORTED EMPLOYMENT

Supported employment is the combination of ongoing support services and paid employment that enables the beneficiary to work in the community. For purposes of this waiver, the definition of "supported employment" is:

- Paid work consisting of 10 or more hours a week, paid at 50 percent of minimum wage or higher.
- Community-based, taking place in integrated work settings where workers with disabilities work alongside people who do not have disabilities.
- For beneficiaries with severe disabilities who require ongoing supports such as job coach, employment specialist, or personal assistant.
- For beneficiaries who require these supports for **less** than 50 percent of their employment hours.

Transportation provided between the beneficiary's place of residence and the site of the supported employment service, or between habilitation sites (in cases where the beneficiary receives habilitation services in more than one place), is included as part of the supported employment and/or habilitation service.

This service must not otherwise be available to the beneficiary through the Rehabilitation Act of 1973, as amended, or under the Individuals with Disabilities Education Act (IDEA).

SUPPORTS AND SERVICE PROVIDER QUALIFICATIONS

Providers of Habilitation/Supports Waiver supports and services are chosen by the beneficiary and others assisting him/her during the person-centered planning process, and must meet the staffing qualifications contained in Michigan's 1915(b) Waiver for Specialty Community Mental Health Services and Supports.

In addition, minimum qualifications are noted below for aide level work (chore, respite, CLS, and out-of-home habilitation). The planning team should also identify other competencies that will assure the best possible outcomes for the beneficiary. Aide level staff who provide services and supports must be:

- At least 18 years of age.
- Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports.
- Able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed.
- In good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- Able to perform basic first aid procedures.

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GENERAL INFORMATION

The Children's Home and Community Based Services Waiver Program (CWP) provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP. Children enrolled in the CWP who had reached age 18 years prior to October 1, 1996 may continue to receive waiver services until age 26.

The PHP will be held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized by the PHP and exceed the Medicaid fee screens or amount, duration and scope parameters. PHPs must submit claims for covered state plan services, as well as children's waiver services that they provide to these beneficiaries.

KEY PROVISIONS

The CWP enables Medicaid to fund necessary home- and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parents, regardless of their parent's income.

The PHP is responsible for assessment of potential waiver candidates. The PHP is also responsible for referring potential waiver candidates by completing the CWP "pre-screen" form and sending it to the DCH to determine priority rating.

Application for the CWP is made through the PHP. The PHP is responsible for the coordination of the child's waiver services. The supports coordinator, the child and his/her family, friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services.

A CWP beneficiary must receive at least one children's waiver service per month in order to retain eligibility.

CLIENT ELIGIBILITY

The following eligibility requirements must be met:

A. The child must have a developmental disability (as defined in Michigan state law), be less than 18 years of age and in need of habilitation services.

B. The child must have a score on the Global Assessment of Functioning (GAF) Scale of 50 or below.

C. The child currently resides with his/her parent or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.

D. The child is at risk of being placed into an ICF/MR facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/MR facility but, with appropriate community support, could return home.

E. The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).

F. The child's intellectual or functional limitations indicate that he/she would be eligible for health, habilitative and active treatment services provided at the ICF/MR level of care.

COVERED WAIVER SERVICES

Covered Medicaid services that continue to be available to CWP beneficiaries are listed alphabetically in Chapter III, Section 3.

SPECIALTY SERVICES

Services provided under Specialty Services include: Music Therapies, Recreation Therapies, Art Therapies, and Massage Therapies. Specialty services may include the following activities: Child and family training; coaching and supervision of staff; monitoring of progress related to goals and objectives; and recommending changes in the plan. This may be used in addition to the traditional professional therapy model included in Medicaid. Services must be directly related to an identified goal in the individual plan of service and approved by the physician. Service providers must meet the PHP's provider qualifications, including appropriate licensure/certification.

The PHP must maintain a record of all Specialty Service costs for audit purposes. Hourly care services are not covered under Specialty Services.

COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) provides assistance to a family in the care of their child while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. The supports, as identified in the individual plan of services, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings.

Individuals who are identified in the individual plan of services to provide CLS to the child and family must meet provider qualifications. Under very limited circumstances, a parent or step-parent who possesses appropriate licensure/certification, special skills, documented training, and is considered a qualified provider, may function and be paid as a provider of this service. This would require documentation that the service being provided is not personal care; this service was not provided during time that the family is responsible to provide the care; and other qualified non-familial providers of these services are not currently available. Reimbursement for parents and step-parents may not exceed 248 hours during 30 consecutive days, and CLS provided by parents may not be used more than twice in a 12-month period, with an annual maximum of 496 hours.

The PHP must maintain the following documentation:

- A log of the CLS must be maintained in the child's record, documenting the provision of activities outlined in the plan.
- Provider qualifications and standards must be maintained for all staff providing services and supports to the child and family.
- All service costs must be maintained in the child's file for audit purposes.

ENHANCED TRANSPORTATION

Transportation costs may be reimbursed when separately specified in the individual plan of services and provided by people other than staff performing CLS, in order to enable a child served by the CWP to gain access to waiver and other community services, activities and resources. Transportation is limited to local distances, where local is defined as within the child's county or a bordering county. This service is an enhancement of transportation services covered under Medicaid. Family, neighbors, friends, or community agencies that can provide this service without charge will be utilized before seeking funding through the CWP; the availability and use of natural supports should be documented in the record.

Parents of children served by the waiver are not entitled to enhanced transportation reimbursement.

RESPITE CARE

Respite Care services are provided to the child on an intermittent or short-term basis because of the absence or need for relief of the parent. Respite is intended to support the parent who is the primary caregiver. This service can be provided by a qualified provider under contract with the PHP in the child's home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative. A parent or guardian may not be considered a provider, nor be reimbursed for this service. In addition to the maximum monthly respite allocation of 96 hours, vacation respite can be used up to 14 days per year and must be used in 24-hour increments.

The cost of room and board cannot be included as part of respite care, unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/MR, nursing facility, or hospital) is not covered by the CWP. When a child requires skilled nursing interventions on a 24-hour exception basis, the maximum daily amount that one nurse can provide is 16 hours. When the family is not available to provide the additional eight hours of care, a second nurse will be required to provide services for the remainder of the 24-hour period.

PSYCHOLOGICAL/BEHAVIORAL TREATMENT

This service provides coaching, supervision and monitoring of CLS staff by professional staff (LLP, MSW, or QMRP). The professional staff will work with parents and CLS staff to implement the plan that addresses services designed to improve the child's social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage.

DIDACTIC SERVICES

This provides for training and counseling services for the families of children served on the CWP. For purposes of this service, "family" is defined as the people who live with or provide care to a child served on the CWP, and may include a parent or siblings. "Family" does not include individuals who are employed to care for the child. Training includes instruction about treatment regimens and use of equipment specified in the plan of services, and shall include updates as necessary to safely maintain the child at home.

Didactic Services is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs. All didactic skill training must be included in the child's individual plan of services and must be provided on a face-to-face basis.

SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Specialized medical equipment and supplies may include devices, controls, or appliances specified in the individual plan of services which enable the child to increase his/her abilities to perform activities of daily living or to perceive, control or communicate with the environment in which he/she lives. This service includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under Medicaid or through other insurances.

The PHP, or its contract agency, may locally authorize medical equipment and supplies as defined in the CWP manual. All other requests for specialized medical equipment and supplies must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, CSHCS, Medicaid. The item must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the individual plan of services. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented.

All items must be prescribed by a physician and determined to be essential to the health, welfare, safety, and independent functioning of the child as specified in the individual plan of services. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following prudent purchase standards. All items must meet applicable standards of manufacture, design and installation. The PHP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase.

Repairs to specialized medical equipment that are not covered benefits through other insurances may be covered with prior approval by the CWP. There must be documentation in the individual plan of services that the specialized medical equipment continues to be of direct medical or remedial benefit to the child. All applicable warranty and insurance coverages must be sought and denied before requesting funding for repairs through the CWP. The PHP, or its contract agency, must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PHP, or its contract agency, must provide evidence of training in the use of the equipment to prevent future incidents.

Items that are not of direct medical or remedial benefit or that are considered to be experimental are not covered. "Experimental" means that the validity of use of the item has not been supported in one or more studies in a refereed professional journal. Furnishings and other non-custom items that may routinely be found in a home are excluded. Also excluded are items that would normally be available to any child and would ordinarily be provided by families. Items that are considered family recreational choices are not covered. The purchase of a vehicle and any repairs or routine maintenance to the vehicle are not covered. Educational supplies are expected to be provided by the school and are not covered.

Vehicle modifications are limited to the installation of lifts, tie-down systems and raised roof or doors in a family-owned full-size van. The modification must be necessary to ensure the accessibility of the child with mobility impairments and the vehicle is the child's primary means of transportation.

Generators may be covered for a beneficiary who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment.

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home, specified in the individual plan of services, which are necessary to ensure the health, welfare and safety of the child, or enable him/her to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment. Requests for EAAs must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, CSHCS, Medicaid. All services shall be provided in accordance with applicable state or local building codes.

Standards of prudent purchase must be followed. The EAA must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance. EAAs shall exclude costs for improvements exclusively required to meet local building codes.

The EAA must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

The EAA must demonstrate cost-effectiveness. The family must apply to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the child's records. The CWP is a funding source of last resort.

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, and are not of direct medical or remedial benefit to the

child. EAAs that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a child's home.

All work must be completed while the child is enrolled in the CWP.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the child's family must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the CWP and the DCH are not obligated for any restoration costs.

If a family purchases or builds a home while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs, such as having a ground floor bath/bedroom if the child has mobility limitations. The CWP does not cover construction costs in a new home, or a home purchased after the beneficiary is enrolled in the waiver. The CWP funds may be authorized to assist with the adaptation noted above (e.g., ramps, grab bars, widening doorways) for a home recently purchased.

Additional square footage may be prior authorized following a DCH specialized housing consultation if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home wheelchair-accessible for a child with mobility impairments to prevent institutionalization; the amount will be determined by the direct medical or remedial need of the beneficiary. The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's records.

PROVIDER QUALIFICATIONS

Individuals who provide respite and CLS must be:

- At least 18 years of age.
- Able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support.
- Documented understanding and skill in implementing the individual plan of services and report on activities performed.
- In good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- Able to perform basic first aid and emergency procedures.
- Trained in recipient rights.
- An employee of the PHP or its contract agency, or an employee of the parent who is paid through a choice voucher arrangement.

Individuals performing supports coordination functions must have:

- A minimum of a Bachelor's degree in a human services field.
- One year of experience working with people with developmental disabilities.

COVERED SERVICES

The following Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the specified region and request services:

1. Unbiased assessment, diagnostic impression, referral and patient placement

Any program/agency performing an assessment, diagnostic impression and referral must be licensed by the Michigan Department of Consumer and Industry Services to perform Screening, Assessment, Referral, and Follow-up (SARF) services under Part 6 of the Administrative Rules for Substance Abuse Programs in Michigan.

a. The current Diagnostic and Statistical Manual of Mental Disorders (DSM) must be used for diagnostic impressions.

b. The current American Society of Addiction Medicine (ASAM) Patient Placement Criteria must be used to determine the appropriate level of care. The ASAM must be used for all admissions, continued stay, and discharge/transfer decisions.

c. An unbiased assessment is defined as the impartial/objective evaluation or appraisal of a beneficiary's need for alcohol and other drug treatment and appropriate placement in a specific treatment service. This assessment process must collect sufficient information to determine an ASAM level of care (LOC) addressing the six dimensions of the current ASAM Patient Placement Criteria. The assessment must be performed before the client can admit into Outpatient, Intensive Outpatient, or any substance abuse treatment service. If a beneficiary is moving from one substance abuse treatment service to another, the assessment process must gather sufficient information to determine that the new LOC is appropriate before admission into the service can occur.

2. Outpatient treatment

a. Individual therapy is face-to-face counseling services with the beneficiary.

b. Family therapy is face-to-face counseling with the beneficiary and his/her significant other and/or traditional or non-traditional family members.

c. Group therapy is face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group-related activities.

Outpatient treatment is an organized, non-residential treatment service or an office practice with clinicians educated/trained in providing professionally-directed alcohol and other drug (AOD) treatment. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week. Examples include weekly or twice weekly individual therapy, group therapy, or a combination of the two. The treatment may be in association with participation in self-help groups.

Treatment must be individualized based on biopsychosocial information, diagnostic evaluation and beneficiary characteristics including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care and discharge, must be based on the ASAM patient placement criteria. Beneficiary participation in the development of their individualized treatment plan must occur and be documented in the beneficiary's treatment record.

Documentation of the beneficiary's participation in their referral and continuing care plan, which must occur prior to discharge, must also be recorded in the beneficiary's file.

3. Intensive outpatient treatment

Intensive outpatient (IOP) treatment is a planned and organized non-residential treatment service in which AOD trained/educated clinicians provide several AOD treatment service components to beneficiaries. Treatment consists of regularly scheduled treatment, usually group therapy, within a structured program, at least three days per week for three or more consecutive hours each day. Examples include day or evening programs in which patients attend a full spectrum of treatment programming. Room and board is not part of this covered service.

Treatment must be individualized based on a biopsychosocial information, diagnostic evaluation and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care and discharge, must be based on the ASAM patient placement criteria. Beneficiary participation in the development of their individualized treatment plan must occur and be documented in the beneficiary's treatment record. Documentation of the beneficiary's participation in their referral and continuing care plan, which must occur prior to discharge, must also be recorded in the beneficiary's file.

4. Office of Pharmacological and Alternative Therapies/Center for Substance Abuse Treatment (OPAT/CSAT) and Federal Drug Administration (FDA) approved Methadone or Levo-Alpha-Acetyl-Methadol (LAAM) pharmacological supports

Covered services for OPAT/CSAT and FDA approved Methadone and LAAM pharmacological supports and laboratory services include:

a. Medication

- Methadone, as ordered by a physician
- LAAM, as ordered by a physician
- other necessary medication ordered by a physician for withdrawal management

b. Physician encounters (monthly)

- medical evaluation
- follow-up care
- supervision of patient medication schedules
- interpretation of laboratory test results
- services for related medical conditions

c. Nursing services

d. Laboratory tests

- any laboratory tests as part of initial examination

- urinalysis for presence of morphine, methadone, barbiturates, amphetamines, cocaine, benzodiazepines and other drugs as indicated, per OPAT/CSAT regulations, federal law CFR42, Part 8, Section 8.12f(6), and the Administrative Rules for Substance Abuse Services Programs in Michigan
- for sexually-transmitted diseases

e. Physical examination

- initial examination required upon admission
- subsequent examinations (as ordered by physician)

f. TB skin test (as ordered by physician)

- required follow-up with positive skin test

Opiate-dependent patients may be provided chemotherapy using methadone or LAAM as an adjunct to substance abuse treatment as allowed in Part 4 of the Administrative Rules for Substance Abuse Services Programs in Michigan. Such services must be performed under the care of a physician licensed to practice medicine in the state of Michigan. The physician must be licensed to prescribe controlled substances, as well as licensed to work at a methadone program. The methadone component of the substance abuse treatment program must be licensed as such by the Michigan Department of Consumer and Industry Services and be certified by the OPAT/CSAT and licensed by the Drug Enforcement Administration.

The current DCH Enrollment Criteria for Methadone Maintenance and Detoxification Program must be followed.

ALLOWABLE SERVICES

The PHPs may provide allowable services from Medicaid savings within their capitation payment (refer to the contract).

EXCLUDED SERVICES

1. Room and board

2. All other services not addressed within Covered or Allowable Services

3. Medicaid Substance Abuse Services Funded Outside the PHP Plan

Some Medicaid-covered services are available to substance abuse beneficiaries, but are provided outside of the PHP Plan. The PHPs are not responsible to pay for the following Medicaid-covered substance abuse services and ancillary services: Acute detoxification; laboratory services related to substance abuse (with the exception of lab services required for Methadone and LAAM); medications used in the treatment/management of addictive disorders; emergency medical care; emergency transportation; substance abuse prevention and treatment which occurs routinely in the context of providing primary health care; and routine transportation to substance abuse treatment services which is the responsibility of the local Family Independence Agency.

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GENERAL INFORMATION

This section is applicable to all PHP programs/provider requirements and pertains to beneficiaries with mental illness and/or developmental disabilities.

The school-based services policy requires cooperative agreements between the PHP and the school-based services provider. These agreements are not changed by the policies in this manual. Any required releases of information are part of the existing requirements of the school-based services provider.

The quality assurance standards for school-based services also requires the coordination of care with other human service agencies where appropriate, including local public health departments, community mental health agencies and the beneficiary's physician or managed care providers. In addition, enrolled school-based providers are required to cooperate with other human service agencies operating within the same service area and are not expected to replace or substitute services already provided by other agencies.

When a beneficiary receives active treatment from a school-based services provider, the services must be coordinated with the PHP. If the PHP provides mental health services for a special education student with serious emotional disturbance or a developmental disability, PHP must coordinate such services and information with special education and other human services agencies serving the student.

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